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ABSTRACT

This book is the first of two volumes designed to highlight and integrate current knowledge about drug dependent women, with a focus on needed services and appropriate delivery systems, as well as to provide useful information for counselors and treatment program developers. The special problems, needs, and characteristics of women drug abusers are discussed. Attention is given to the roles of age, cultural background, social class, drugs of choice, and differing lifestyles in terms of their effects on women's attitudes and behavior. The first of 11 chapters in this book provides an introduction to intervention strategies for drug dependent women. Chapter Two reviews literature, research data, and findings about women and drugs. Chapter Three outlines the components of a comprehensive intake and diagnostic process. Chapter Four describes the five roles of counselors who work with chemically dependent women. Chapter Five deals with referrals and developing community linkages. Chapters Six and Seven focus on health and medical issues. Vocational rehabilitation and employment development are described in Chapter Eight, and family therapy approaches are reviewed in Chapter Nine. The final two chapters deal with the chemically dependent woman and her children. Childcare services and parenting education are also discussed. (NRB)

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TREATMENT RESEARCH MONOGRAPH SERIES

Treatment Services for Drug Dependent Women

VOLUME I

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The Treatment Research and Monograph Series are issued by the Treatment Research and Assessment Branch, Division of Prevention and Treatment Development, National Institute on Drug Abuse (NIDA). Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings from Branch-sponsored studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

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Foreword

For the past decade, a great deal of information has been accumulated about the functioning of drug dependent women, but this has been widely scattered and not readily accessible in a single source. Consequently, there have been few attempts to apply this knowledge in treating drug dependent women. This book provides a rich storehouse of material on drug dependent women and their treatment. It is essential to communicate the material to clinicians, program planners, and administrators to provide them with a better understanding of drug dependent women so that efforts to help these women are more effective.

During their early development, drug programs were designed primarily by and for men. As women were introduced into treatment, their failure to adjust to a program and find the help they needed was seen as "their problem." Much progress has been made since the early days when we had a stereotypic image of addicts. We now recognize that drug abusers and addicts are heterogeneous, coming from all ethnic, social, and economic groups at all ages, and representing both sexes. Research into the special needs of women clients advanced as a growing number of women were becoming involved in the study of drug and alcohol abuse. We have learned that as women's roles, expectations, and pressures changed, there has been an upsurge in their use of drugs as a mode of coping. In fact, we have found that more women than men are now dependent on prescription sedatives and stimulants.

The women's movement has made those responsible for treating drug abusers more sensitive to women's issues. What has been lacking, up until now, is practical advice on how to provide basic services which will be acceptable and meaningful to female clients. These two volumes pull together the extant knowledge in the field on the special problems, needs, and characteristics of women drug abusers. They also explain the application of this knowledge ranging from initial intake to counseling, referrals, medical and health services, employment development, family therapy, and child care and parenting services.

Ample attention is given in this work to the various roles of age, cultural background, social class, drugs of choice, and differing lifestyles in terms of the effects they have on women's attitudes and behavior. Moreover, what is written here is relevant to women in general, with or without drug problems, and can be useful to professionals outside the drug field as well. Moreover, the humanistic orientation in these two volumes is as valid for men as it is for women. As the values underlying these chapters are put into practice, it is hoped that both men and women will benefit. In that spirit, treatment program staff can expect to find invaluable ideas, and guidelines to assist them in their efforts to deliver more effective services to women clients. A variety of day-to-day problems faced by counselors, nurses, and others in treating women are discussed in detail.

These volumes represent a benchmark collection concerning the treatment of drug dependent women. As such, they should be viewed as only part of a growing body of literature in this area and not the total extent of our concern. As these suggestions are implemented and sensitivity to the needs of women clients is broadened, questions for further research are certain to arise and further improvements in service delivery to clients--both women and men--will hopefully take place. Therefore, I am looking forward to the wide dissemination and acceptance of this book.

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Preface

Policymakers, researchers, and treatment personnel have come to appreciate the extent to which the treatment needs of drug dependent women differ in both kind and degree from those of their male counterparts. After a delayed start in studying the special needs of women, significant progress has been made in identifying the unique characteristics of drug dependent women and in evaluating the effectiveness of services to meet those needs and characteristics.

Thus, a solid research base has been established, not only in specialized areas of concern such as treatment of drug dependent pregnant women and their offspring, but also in more typical and perhaps more insidious problem areas. These include services to drug dependent women with overwhelming personal problems and medical complications. Often these women are coping alone and struggling for self-respect and an opportunity to gain control over their lives.

A wealth of knowledge about drug dependent women now exists, and treatment methods and approaches have been tested and found to be effective. Yet, practitioners in the field have no central source of all this information and do not generally get the information in a format that is easily accessible. This volume is intended to help fill this gap.

The purpose of this book, then, is to provide new knowledge about drug dependent women in a practical format so that it can be more easily applied in the field. The book is organized in a series of how-to-do-it chapters which describe how to provide basic services to women clients based on the knowledge accumulated.

The terms "drug dependent" and "chemically dependent" are used interchangeably in this book, reflecting the fact that multiple drug use patterns (including combined or sequential use of alcohol and drugs) have become more prevalent than they were in the past.

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1.
Intervention Strategies for Drug Dependent Women: An Introduction

Beth Glover Reed, Ph.D.

The purpose of this two-volume book is to highlight and integrate current knowledge about drug dependent women, with a focus on the services they need and how to deliver them. As a result of investments made in research and clinical practice during the past decade, a wealth of information is now available regarding the patterns of drug and alcohol use and abuse among women and the characteristics, problems, and needs for service among those who become chemically dependent. Also, other research on women has produced knowledge of direct relevance to the treatment of drug dependent women. Keeping up with this knowledge is difficult, however, and research results have not been readily available to the direct providers of service to women in chemical dependency treatment programs. Thus, the chapters in this book have been developed to compile and integrate available knowledge on women, drug dependency, and related areas; establish standards about services chemically dependent women need; and provide useful how-to-do-it information to help counselors and treatment programs deliver new or improved services for women clients.

A major assumption underlying this book is that issues of drug dependency in women cannot be addressed without an understanding of the fundamental role that gender plays in defining the following:

- Individual identity, coping style, and skills;
- The structure of a person's life cycle and the nature of life experience, including the psychological, social, and cultural realities one faces; and
- The opportunities and resources available.

While large areas of overlap and similarities exist between women and men, they also can be described as living in fundamentally different cultures. Society holds different expectations about appropriate male and female roles and related behaviors, and offers different opportunities to women than to men. The sexes are socialized differently, and thus often grow up with different world-views, interaction styles, ways of seeking pleasure and managing pain, skills, and problem areas.

Some theorists have described women's and men's roles and behaviors as complementary and arising from a division of labor necessary to maintain a family within society (e.g., Bales and Slater 1955; Parsons and Bales 1955). Others (e.g., Lewis 1976) argue that the notion of men and women's being "opposites" is simplistic and that aspects of both masculine and feminine stereotypes and gender role socialization are limiting and even crippling in their extremes. Gender role socialization leaves members of both genders with areas of undeveloped potential and conflicts, limits choices for both men and women, and results in men and women's being dependent on each other in ways that are potentially destructive for each.

Women and men, of course, differ biologically and some of these differences influence the ways drugs affect their bodies. Many assumed physical and biologically determined psychological differences, however, have been shown to be myths and others vary from situation to situation (Maccoby and Jacklin 1974). In fact, researchers are increasingly challenging the idea that masculinity and femininity are polar opposites; instead, they have developed the concept of androgeny [from the Greek words andro meaning male and gyn meaning female] to suggest a flexible integration, in a single person, of characteristics usually associated exclusively with women or men (Bem 1974; Kaplan and Bean 1976). Persons who are most adaptable are those who have developed and can use the positive attributes associated with both masculine and feminine stereotypes.

As described more fully later in this chapter, the service needs and characteristics of drug dependent women are similar in many ways to those of women who do not become chemically dependent. Counselors need to provide services to women that are sensitive to common differences between women and men but not based on stereotypes and untested assumptions which can perpetuate ineffective coping patterns. To do this, counselors must acquire some knowledge of the ways in which women's and men's social status, roles, and socialization differ and the treatment implications of these differences. They must recognize strengths and potentials women are likely to bring to treatment and know how to build on these. Counselors also must help women clients develop abilities and capacities that have been limited through past experience and gender role socialization, and establish more adaptive ways of managing life situations that have caused conflict and stress. They may need to work to create more options for women in their community. Creating new support systems and opportunities that will help women find more self-affirming ways of viewing themselves will also be important.

In fact, both research and clinical experience suggest the following:

- Chemically dependent women need most of the same basic services that men do, but some services are even more important for women (e.g., women have different medical problems and many have less developed vocational identities and skills than men).

- The foci and style of services to women should:

    1. Be sensitive to the fact that many drug dependent women suffer from low self-esteem, depression, anxiety, feelings of isolation, and detachment (e.g., confrontation and self-confession modes of therapy are likely to increase self-blame in women and make problems with low self-esteem and depression worse);

    2. Take into account and build on women's strengths, which are usually different from men's (e.g., expressive and relationship skills);

    3. Help women work on developing capabilities and skills limited by women's gender role socialization (e.g., assertiveness); and

    4. Be compatible with women's styles of expressing themselves, thinking, and relating to others.

- Women are also likely to need services that programs usually do not provide for men clients, e.g., women are generally more responsible for and concerned about their children; they have different survival needs; they are more likely to have been battered or assaulted; and they are often more socially isolated or involved in intimate relationships with men who are also drug dependent.

- Chemically dependent women need much more contact and interaction with other women, as service providers and with other clients and "straight" women, in order to:

    1. Develop support networks;

    2. Work together on problems common among women; and

    3. Through sharing and skill-building activities, minimize the self-blame and dependent orientations that are often barriers to the development of confidence and well-being.

Despite all the knowledge gained about women and drug dependency over the past 10 years, evidence suggests that treatment programs have been slow to incorporate changes needed to provide effective services to women. In chemical dependency programs, as in other types of human services, providers either have not taken into account some of the fundamental ways in which women's lives and opportunities differ from those of men, or have assumed differences based on stereotyped ideas about the appropriate roles and behavior of women. Education and training programs in the health, behavioral, and social sciences are only beginning to incorporate the new knowledge about women and gender arising from research and the new scholarship on women. Many counselors have developed styles, methods, and techniques from their own experiences or through staff training activities and supervision, thus perpetuating current practices and ways of thinking.

Many treatment models have evolved as a result of trial and error, usually outside, and often in spite of, the mainstream of other health, mental health, and social services. Staff of these service agencies often perceive alcoholics and drug addicts as unmotivated, difficult, and undesirable clients. Drug abuse and alcoholism frequently were considered as male problems, and treatment models have been designed primarily for and by men. Treatment ideologies have considered drug dependency to be either a moral lapse, a problem in character development, or a medical problem. Until recently, self-help groups also have been largely designed for and coordinated by men.

Although both the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have developed materials and training packages on the needs of women (National Institute on Drug Abuse 1979; National Institute on Alcohol Abuse and Alcholism 1979b), few services sensitive to the needs of drug dependent women are now available. A study done for the U.S. Office for Civil Rights on the extent of sex discrimination in health and human development services (Naierman et al. 1979) found that drug and alcohol services were generally the most lacking in

- Their availability to women;
- Offering the types and quality of support services needed by women; and
- The adequacy of their referral and followup procedures for women.

A national study conducted in 1980 found that only a small percentage of drug treatment programs can provide the special treatment services needed by women (Beschner and Thompson 1981). The availability, scope, and quality of services generally available for alcoholic women are similarly limited (Homiller 1977; National Institute on Alcohol Abuse and Alcoholism 1979b).

The reasons for these continuing limitations have not been well documented, but probably are related to:

- Insufficient financial and staff resources to establish the full range of services needed;
- Inadequate knowledge about women;
- A scarcity of well-targeted training materials;
- The inability to plan and implement the required services; and
- Lack of interest in or commitment to the delivery of comprehensive services for women.

The chapters in this book were developed to address some of these barriers, to establish more effective and useful services for chemically dependent women, and to facilitate the implementation of these services. Of course, how-to-do-it manuals cannot change a fundamental lack of commitment, but they can address the other four barriers to change to some degree. Programs and administrators should be more willing to adapt their programs to serve women better if they are convinced there is a need and have some idea about the services necessary, how to deliver them, and where to get resources. Specifically, this book's goals are:

- To highlight the pervasive ways in which gender influences the range and types of services needed;
- To summarize what is known about drug dependence in women, emphasizing treatment and other service needs and useful modes of service delivery;
- To outline the range and types of services needed to intervene effectively with chemically dependent women, and to establish standards for these services;
- To provide practical suggestions, guidelines, step-by-step descriptions of procedures, strategies, and helpful tools so that each chapter is, in part, a "how-to-do-it" guide; and
- To include sections on recommended procedures and materials for staff training and supervision, ways to interface with and use existing community programs and services, and methods of creating alternatives from, or making more creative use of, already available resources.

USE OF THESE CHAPTERS

In these times of decreasing financial and staff resources, programs that do want to expand and improve services to women will need to be creative in securing resources (e.g., materials, volunteers, exchange arrangements with other programs), in tending to their own survival, and in minimizing staff burnout without sacrificing flexible and comprehensive programing. These chapters should be helpful in that process by stimulating existing staff to think about, plan, and implement services needed by women, use approaches sensitive to women, and consider how new resources can be obtained relatively inexpensively.

Although these two volumes are intended primarily to be resource materials for persons who provide direct services to drug dependent women, those concerned about policy formulation should find many of the chapters useful. Planners, managers, and other decisionmakers can use materials in the chapters to help in developing standards and allocating resources for future services. Since the information is based on research findings, much of it has implications for future research.

Since many, perhaps most, of the issues faced by chemically dependent women are similar to those that other women face, many chapters will be useful in human service settings not directly concerned with drug dependency. Educators and trainers of persons preparing to work with women in various human service settings will find them useful as well.

Each chapter can be used as a resource guide:

- To help programs establish a new service;
- To provide guidelines for existing services; or
- To serve as a resource in ongoing work

Some of the chapters are long, with detailed how-to-do-it guides and resource sections. The reader may wish to skim these sections to locate specific how-to-do-it information that can be useful in current work.

DEVELOPMENT OF THE BOOK

First, persons knowledgeable in a particular area were identified from their previous publications or recommendations by others in the field. Criteria used to select authors included: (1) sensitivity to women's issues; (2) knowledge about treatment and related services (usually with direct treatment experience); (3) ability to interpret and use research findings; and (4) skill in translating all of the above into a practical, how-to-do-it style. First drafts were reviewed by the editors and, where appropriate, by other technical reviewers. In some cases, second and third drafts were written based on information provided by persons with particular knowledge or skills that would augment the original work. Each chapter was written as a self-contained unit, although cross-references are given as appropriate. Wherever possible, the results of research-demonstration projects, research studies, and documented clinical experience have been integrated. Each chapter is designed to be an example of research utilization (i.e., making practical use of available data) and the ways research results can be used to inform and enhance service delivery.

KEY DEFINITIONS

Drug dependency or chemical dependency is defined broadly to include compulsive or destructive use of many types of psychoactive substances, including heroin, prescription drugs, over-the-counter (OTC) drugs, and alcohol. Since less is known about women who are dependent on prescription and OTC drugs, the bulk of the available research data and clinical experience comes from women who use heroin or alcohol. This book is based largely on work done in the drug treatment field, however. Although some data and examples of alcoholic women have been included and some of the authors have extensive experience with women who are dependent primarily on alcohol, knowledge from the alcohol field is not integrated into every chapter.

Actually, dichotomizing substance abuse among men and women into two categories--drugs and alcohol--has become increasingly difficult. Women who use/abuse different chemicals share many characteristics with each other and with women who are not drug dependent. Differences among them are as much related to age, ethnicity, race, class, or lifestyle as they are to the specific chemical they chose. And, of course, many women use multiple drugs (in combination or sequentially); distinguishing one chemical substance as a primary drug is often difficult. The authors have tried to be explicit when data, an issue, or intervention being presented concerns primarily one particular chemical, e.g., heroin addiction.

The term gender, rather than sex, is used deliberately to include the sociocultural as well as the biological meanings associated with "female" and "male" in this society. Although the focus of the chapters is explicitly on women, much of the information should be useful also for working with men.

WOMEN'S LIVES, DRUG DEPENDENCY, AND TREATMENT IMPLICATIONS

Many problems and issues that treatment of drug dependent women must address are related more to their being women than to their chemical dependency. This understanding has guided the development of the book and provided the rationale for the selection of particular topics and intervention strategies. In this section, data on chemically dependent women are compared with available knowledge of women's situations and circumstances in general. Treatment managers and counselors who understand these relationships will be more able to apply the various intervention strategies described and can incorporate and adapt much of the new knowledge and treatment approaches being developed for women in other fields into their own work.

Economically, drug dependent women reflect the situation of women relative to men within the general society, although this varies somewhat depending on the drug involved and the socioeconomic class of the individual. Compared with chemically dependent men, chemically dependent women have lower incomes, are more dependent on social services, have less evidence of a work-related identity, and have poorer job histories and less vocational preparation that would enable them to become more economically self-supporting. Thus, vocational preparation and rehabilitation programs are likely to be especially important within a treatment program for women, as addressed in chapter 8 of this volume.

In addition, a large majority of drug dependent women have and many are concerned about and remain responsible for the welfare of their children, which also limits their abilities to be wholly self-supporting and to have social and supportive contacts. Treatment programs need to be concerned about helping chemically dependent women with their parenting skills, and with making arrangements for the care of their children so that mothers are able to participate in treatment. A number of chapters in these books (10 and 11 in this volume and several in the second) address childcare or parenting issues. As will become apparent, attention to childcare and parenting training also can help develop the woman's trust in the program, increase her self-esteem, strengthen her family, and decrease the problems her children may have in the future.

Many drug dependent women are relatively isolated socially. Either they withdraw from contacts with people they have been close to, or they are more often rejected by families and friends than men are in similar circumstances. Chemically dependent women, as compared with men, are more likely to be alone, or to be with partners who are also chemically dependent and may be ambivalent about their recovering from their dependency. Because of their socialization to nurture and serve others, women are usually responsive to and concerned about the reactions of others to their behavior. As Sutker notes in chapter 2 of this volume, drug dependent women may come from more disturbed families-of-origin although the data here are not consistent.

Women's family roles and interpersonal orientation mean that family-oriented interventions may be particularly useful. Family therapy approaches can help a woman separate from, establish more productive relationships with, and understand the effects of her family-of-origin, and can help her develop more productive patterns with her spouse/partner and/or children (see chapter 9, this volume).

There is considerable evidence that women's and men's roles are not valued equally by society (Lockheed and Hall 1976; Meeker and Weitzel-O'Neill 1977). Men's contributions are more valued than women's not only monetarily, but also in terms of status and prestige. A large proportion of the characteristics associated with masculinity also are considered more "healthy" in several studies with different types of clinicians (e.g., Broverman et al. 1970). Those with lower status often internalize feelings that they have less value, feel less good about themselves (lower self-esteem), and orient themselves toward those who have more power.

Thus, they devalue themselves and others like themselves. They have lower expectations for their lives, and tend to be more concerned about surviving and minimizing their discomfort than about getting ahead. In fact, the literature is very consistent in finding that women express lower levels of self-esteem and higher levels of anxiety and depression than men across all social classes (Cloward and Piven 1979; Gomberg and Franks 1979; Guttentag et al. 1980; Lewis 1976).

Drug dependent women have been found to have lower levels of self-esteem and higher levels of depression and anxiety than drug dependent men, and than women who are not drug dependent. [There is, however, some indication that their scores are not much different from those of women with other forms of deviant labels (Kandel 1981).] Thus, the chemical dependency serves to reduce self-esteem and increase depression and anxiety for both men and women but does not change the pattern between them. Depression, anxiety, and low self-esteem can be immobilizing and must be addressed within treatment for most chemically dependent women.

"Learned helplessness," resulting from physical and emotional assault and extreme feelings of powerlessness, is also characteristic of many drug dependent women. This condition is found more often in women than in men, especially those who have low levels of self-esteem and/or high levels of depression (Seligman 1974; Walker 1979). A woman feels unable to change her situation and sees no alternatives other than her current circumstances. In animals, these behaviors can be developed by negatively reinforcing the animal no matter what it does to try to escape or control its situation. In a remarkably short period of time, animals stop trying and will even die rather than struggle for their lives. The animal learns to be helpless quickly; unlearning these patterns takes step-by-step learning about how to be less helpless, with a great many successes and relapses before the animal appears to be at all willing to take any initiative in its situation. Chemically dependent women with patterns of learned helplessness will need repeated success experiences and will have to learn to think more positively about themselves and their capabilities. They need experiences within and outside of the treatment program which will be empowering. These include developing (1) useful skills that will enable them to survive without using drugs, (2) more rewarding relationships, (3) economic self-sufficiency, and (4) pride in who they are and what they can accomplish.

Empowerment counseling strategies and their rationale will be discussed more completely in the introduction to volume 2. The women-oriented services presented in chapters 2 through 6 in volume 2 explicitly present ways that women can be helped to develop more confidence, relationships, and the skills to help them feel (and be) more powerful and independent. This is a theme that runs through most chapters, however, especially chapter 4 in this volume on counseling.

In general, societal expectations about acceptable behavior in adult women are more limited than those for men, especially in relation to sexual activities and assertiveness. Expression of anger or aggression is considered "unfeminine" and is discouraged, so many women not only have few skills in asserting themselves but also may have considerable conflict and guilt about even feeling angry. This contributes substantially to feelings of powerlessness and helplessness. Many drug dependency programs have developed assertiveness training programs for women clients, to help them accept their needs as valid, express effectively their angry feelings, and learn the behaviors necessary to actively seek ways to meet their needs. Learning to be more assertive also increases self-esteem and makes it less likely that a woman will be victimized by those around her. Survival skills training programs allow women to have a series of success experiences and provide them with important tools to become and feel more independent and powerful. They may also be necessary if a woman is to become more economically self-sufficient. Chapters describing assertiveness training and survival skill training are included in volume 2.

Many chemically dependent women feel that they have few options other than to endure and continue with their responsibilities. Cloward and Piven (1979) propose that this is a common coping pattern for women. They suggest that it is difficult for a woman to see other options if she believes that her situation is biologically determined. Educational programs oriented to help women gain a better understanding of their roles and circumstances (e.g., identifying myths and emphasizing women's potential and not their biological limitations) can be useful in promoting less restrictive views about what is "appropriate feminine behavior." Several chapters in volume 2 contain resource material that can be used in such education programs.

Cloward and Piven (1979) also feel that women accept their limited circumstances because their homemaker and family roles prevent them from having enough contact with other women. By being isolated, these women cannot fully understand the relationship between the situations they face and broader patterns within society. As a result, there is a tendency to blame themselves for situations they cannot control (Deaux and Emswiller 1974; Frieze et al. in press), and they fail to recognize that many of the problems they face are problems for all women. Activities with other women can help reduce their social isolation and provide opportunity to recognize and work together on their common circumstances. Several chapters in volume 2 describe how to run all-women activities and groups.

Further, many chemicals seem to affect women's bodies more quickly and more destructively than they do men's. Moreover, women's reproductive systems are more complex. Chapters 6 and 7 in this volume emphasize medical and health services.

Women are less likely than men to try to deny their problems. They cope by seeking help--from family, friends, and particularly from medical, mental health, and religious professionals and clinics. Women are the primary consumers of health care for both themselves and their families. They tend to define their feelings of dis-ease as health problems and take both physical and more global problems to their doctors. Often, of course, they are given medication for their "symptoms." Women, in fact, are more likely than men to perceive their use of chemicals as a way of coping and often cite particular distressing incidents or problems they define as health-related that began their slide into drug dependency. Programs that have comprehensive health services or work with women on activities that promote health-related activities are likely to attract chemically dependent women and help them develop health behaviors incompatible with a dependency on drugs. The health promotion chapter in volume 2 describes some ways to plan and organize health-related activities for women.

Finally, as with other groups of women, drug dependent women are much less involved with the criminal justice system than drug dependent men. Many do have legal problems but they are usually less extensive than those of men in comparable circumstances. Many of them involve civil matters and child custody. Thus, legal counseling and advocacy for women clients may involve different emphases and strategies than similar work with men (see the legal counseling chapter in volume 2).

DIFFERENCES AMONG DRUG DEPENDENT WOMEN

Generalizing about all drug dependent women (and men) obscures important differences that have profound implications for treatment planning, styles of service delivery, and the counselor-client relationship. These differences include age, race, class, ethnicity, lifestyle, and time in history. Authors have attempted to highlight the likely range of client styles and needs by providing many examples. Obviously, all women will not fit the modal patterns described, so it is important to keep in mind some of the ways in which they may differ.

AGE

Age makes a difference in a number of ways. Although many similarities exist in the issues that women and men face at each age, women's socialization and life circumstances are also quite different than men's generally throughout the life course (Rossi 1980). Issues faced by an adolescent who is trying to stop being dependent on drugs are different from those faced by a woman in her mid-thirties whose children are moving into their teens, and whose husband has just left her. Drug use that begins to interfere with one's life and active coping during adolescence will have different effects than will problematic drug use that occurs later in life, since many experiences and skills important for being an effective adult are acquired during adolescence.

Program staff working with adolescent women will find that dealing with drug use and being sensitive to gender issues are only part of their responsibilities. Understanding adolescence and the special issues and problems faced by young women during adolescence is equally important (Konopka 1976). A young woman's peer groups are smaller than those of her male counterpart, and she may have more difficulties in developing an autonomous identity. Emerging sexuality raises different issues for girls than for boys, even if there is no history of assault or incest. The young woman often feels that making a place for herself in the world involves finding a male partner and bearing children. Struggle for a separate identity may come later, often after she is responsible for children and inadequately prepared to support herself in the economic marketplace. Issues of her appearance and a sense of fading social value as she ages (given society's youthful and often narrow standards of female beauty), the likelihood of having a lower income than men do, and the relative certainty of leading a longer life than men will all raise different issues for a woman as she grows older.

Counselors will need to be sensitive to the life tasks faced by their clients at each age, how these differ for women and men, and how coping skills or life tasks at each stage may have been disrupted by a woman's drug dependency. Effective treatment may depend not only on being sensitive to the life issues faced at a client's current age, but also on helping her catch up in those areas that her drug use may have disrupted. Several recent books are available that outline some of the key issues for women at different life stages (Konopka 1976; Rubin 1979; Scarf 1980; Sheehy 1977).

Counselors of lesbians also need to understand that much of the research and literature on life cycle issues for women assumes a heterosexual orientation. (See "Treatment Strategies for Drug Dependent Lesbian Clients" in volume 2.) The woman who is not moving toward an eventual partnership with a man may feel especially isolated and "different" during adolescence. The sequence of developing her own identity and seeking autonomy and intimacy may be quite different from that experienced by many heterosexual women. The timing of her recognition and acceptance of her lesbianism will influence the life choices she has made or will make.

RACE/ETHNICITY/SUBCULTURE/SOCIOECONOMIC CLASS

Other ways in which women will differ from each other are in their ethnic and racial characteristics, and their socioeconomic class. Cultural norms regarding appropriate gender behaviors differ by social class and across ethnic and racial groups. The data available about racial and ethnic differences among drug dependent women make it clear that many different types of women become chemically dependent and face very different life circumstances and opportunities. They probably also have different world views, all of which need to be understood as part of treatment planning and the counseling process.

In addition to being sensitive to issues involved in cross-cultural counseling and in working with the effects of racism and oppression, a counselor should know something about the roles and expectations for women within a particular class or ethnic group. Again, examples of different types of women are used in most chapters, but the reader is urged also to explore some of the resource materials available for counselors about being sensitive to racial, class, and minority issues in counseling (e.g., Logan 1981; Marsella and Pedersen 1981; Sotomayor 1976; Waltz 1978). While these sources rarely address gender issues directly, other resources are available which will allow the counselor to understand more fully how women's lives, strengths, problems, and expectations for themselves and others may vary depending on their backgrounds (e.g., Coles and Coles 1978, 1980; Hinman and Bolton 1980; Ladner 1971; Lerner 1973; Melville 1980; Rubin 1976).

Many minority women, for instance, have always known they must be prepared to support themselves or contribute to their family's support. They have never felt they had the option of not working, or had the dependency training that many women experience who grow up expecting marriage and being "taken care of" economically by a man. Although minority women still may settle for less than they need to and require help with planning and acquiring needed skills, many will have had numerous role models of women who survived without a man and supported their families.

In many subcultures, women are also more comfortable in expressing anger and being assertive and will not have the degree of conflict in this area that others may have. Assertiveness training may thus be less relevant for some groups of women. The issues faced by a counselor working with a woman from a middle class family with some college education who is depressed about her marriage will differ from those confronted by a woman with a 10th-grade education who has always lived in the inner city.

DRUGS OF CHOICE

Like men, women choose the drugs they use for a variety of reasons. Although more women report using drugs to cope with life while men say they use drugs more for social reasons or pleasure (e.g., Horn and Wanberg 1973; Ryan 1980; Schuckit and Morrissey 1976), many women also begin drug use in search of pleasure or because their men or their friends are using them. Issues of legality, price, availability, and acceptability among one's peers are also important. A type or class of drugs may be chosen because of its particular effects. A counselor must understand why drugs were first used and what purposes they came to serve in the lives of women clients. Different drugs have different effects on the body and require specialized knowledge to assess the amount of use, and detoxification and withdrawal protocols. Users of multiple drugs present different issues in treatment from those with a dependency on one particular drug. Counselors of women maintained on methadone also require some special knowledge.

Especially programs with staff who are women-identified may find that staff members don't pay enough attention to the various issues related to the drugs used and their effects. They may over-identify with women clients, and establish unrealistic expectations by not recognizing ways in which women with different backgrounds and life experiences differ from themselves. Authors have tried to note situations in which this is likely, but did not have the resources to develop sections that focus on particular drugs or drug combinations, their effects, and treatment implications.

LIFESTYLE

This is related to all of the above, and is very important to consider in providing services for chemically dependent women. Women who are "street-wise" will present somewhat different treatment issues and may be attracted to programs with different styles than will women who are more invested in "straight" lifestyles. These two groups will have different value systems on several important dimensions, and their social networks will differ, as will the ways they interact with others, dress, and so forth. Women from dissimilar lifestyles can learn much from each other in treatment, but only if each woman's lifestyle is respected.

Of particular concern in this area, for women, are those who have been involved in prostitution, either to support themselves or their habit, or as a lifestyle before or after their chemical dependency. Evidence exists that these women face particular obstacles to treatment. They are often stigmatized by other clients, may suffer from particularly low levels of self-esteem and high levels of depression, may have a history of being exploited and find it difficult to maintain meaningful relationships, etc. (Baizerman et al. 1979; James 1978, 1980). They may also bring multiple legal problems into treatment, and have a hard time developing an alternative career in the "straight" world. Only programs that are sensitive to these issues and work to decrease the stigma and develop support systems and feelings of self-worth are likely to have some success with women who have been prostitutes.

ORGANIZATION OF THIS VOLUME

Chapter 2, written by Patricia Sutker, reviews some of the pertinent literature, research data, and findings on women and drugs. Its intent is to provide a framework and context for later chapters, highlighting findings that are most relevant for treatment planning. The review focuses primarily on current knowledge about licit and illicit drug use patterns of women, the characteristics of these women, and implications for treatment.

In chapter 3, Paddy Cook, Christopher D'Amanda, and Elaine Benciavengo outline the components of a comprehensive intake process. They describe the steps in intake, various methods of completing an intake assessment, and the appropriate atmosphere and procedures for working with women experiencing a crisis and withdrawal from drugs. The authors specify the types of information that should be collected, highlighting areas likely to be important for women, and describe how to assimilate this knowledge into a preliminary treatment plan. They stress that accurate and thorough assessment of a woman's needs and circumstances is the first step in delivering competent and effective services.

In chapter 4, Landry Wildwind and Susan Samson outline the five roles of counselors who work with chemically dependent women. They describe the needs of women coming into treatment (primarily for heroin addiction) and suggest ways that the counselor can coordinate services and keep abreast of information about clients. The authors explain how to conduct an in-depth assessment and develop both short- and long-term treatment plans. They then describe the various forms of resistance to change in drug dependent women and ways counselors can deal with each. Throughout, the authors stress the difficulties involved in counseling women who have multiple problems and describe ways that both the counselor and the program can develop support systems to provide effective services while limiting staff burnout and disillusionment.

Chapter 5 deals with developing community linkages. Judith Kovach describes how a program can decide which services should be delivered directly by the program and which services the program should obtain from outside resources. She outlines the range of services chemically dependent women are likely to need and ways the program can identify community resources that can provide such services. Most programs will not have the resources to meet all the needs of women who seek services from them, especially as money becomes scarce. Moreover, although a counselor may wish to encourage dependency on the treatment program in the early stages of treatment, the more relationships can be developed between clients and appropriate service providers in the community, the more likely clients will make smooth transitions from treatment into independent living within the community. The author discusses how a program can develop community linkages at the program level and describes different models a program can use to coordinate and monitor the referrals they make. The chapter also addresses issues in building relationships with other agencies and the types of training that may be necessary to help staff of other agencies increase their sensitivity to and acceptance of chemically dependent women.

Chapters 6 and 7 are concerned with health and medical issues, a very crucial area of services to drug dependent women. Many come into treatment because of medical concerns. Not only do women have more, and some different, health problems than men, but in typical treatment programs for chemical dependency, they are likely to receive less thorough diagnostic assessments medically at intake (largely because many programs do not routinely do gynecological exams) and less complete medical services over the course of treatment.

Most drug and alcohol programs cannot afford to provide comprehensive medical services. Each program, however, has an obligation to make sure that all clients obtain thorough health exams and that their health problems and needs are included in treatment planning. In chapter 6, Josette Mondanaro describes how a program can develop comprehensive health services using existing program resources. She outlines the health needs of most women clients, and describes ways a program can address these needs. Dr. Mondanaro describes women's reproductive and health needs in chapter 7. Meeting these needs can affect a woman's overall health and result in long-term preventative effects as well.

In chapter 8, Robert Inskeep describes some of the vocational needs of drug dependent women and the issues a program must address in establishing an effective vocational rehabilitation component. Contrary to beliefs and practices in some programs, many chemically dependent women are very invested in finding jobs; for many, being able to earn an independent income will be directly related to successful rehabilitation. Moreover, most of these women are dependent on public assistance or others for support if they cannot work, and many are responsible for the welfare of children. The author describes the steps involved in developing rehabilitation services, ways to obtain the information and necessary resources, and special issues that women face in seeking employment. He also discusses ways a counselor can work with a woman to prepare her for interviews and support her job-seeking efforts and adjustments on the job.

Based on evidence that family therapy approaches are useful with drug dependent persons and their families, Bennet Wolper and Zona Scheiner describe in chapter 9 what family therapy is and how several approaches differ in their definitions of the family, with whom they work, and how they work. The authors describe several family situations and ways these situations might be understood from a systems perspective. Three major theories (intergenerational, strategic communications, and structural) are presented, and two others (multiple family group therapy and ecological networking approaches) that are likely to be especially relevant for some types of women are considered also. The authors describe how various family therapists view drug dependency in women, alert the readers to particular issues in family therapy when a woman is the symptom bearer for the family, and describe various intervention approaches. The chapter should provide readers with an understanding of which model might best fit their styles and clients' needs. Some tools are included that can be used immediately to help with assessment and intervention planning.

Finally, two chapters deal with the chemically dependent woman and her children. In chapter 10, Margaret Blasinsky discusses a woman's need for childcare and how a program can help her locate appropriate childcare services, assess the quality of the childcare available, and work with the woman about childcare concerns. Many drug dependent women are not able to participate in treatment without the availability of childcare services. In chapter 11, Nina Lief describes a parenting training program for parents of young children age 3 and under. She outlines the principles on which the program is based and how it can be organized and implemented. Since many drug dependent women are invested in their children and in being good mothers, services to children and attention to parenting will build on this motivation and raise self-esteem. Dr. Lief presents preliminary evidence that, with support and training, many chemically dependent women can provide competent parenting, and, in the process, benefit themselves.

VOLUME 2

Volume 2 continues many of the themes begun in this volume, and contains a cluster of chapters which focus on the issues, skills, and strategies necessary to help drug dependent women:

- Gain confidence, self-esteem, and feelings of power;
- Develop the skill areas that are needed for survival but are often stunted by women's gender role socialization (e.g., assertiveness, financial management);
- Address issues shown to be of particular importance in treatment of drug dependency in women (e.g., promotion of health, sexuality, body and self-image, histories of sexual assault and victimization);
- Work together with other women on common issues and problems (using all-women group activities); and
- Express and learn to value their feelings, ideas, and aspirations, and develop plans based on these.

In addition, one chapter discusses how a program can work with those who interact with and care about a drug dependent woman to motivate her to seek treatment. Another describes the legal issues faced by chemically dependent women and how counselors can provide legal counseling. Some chapters describe how to work with special populations of women (e.g., drug dependent lesbians) and others continue to address special needs and programs for the drug dependent woman and her child. One chapter is directed to men counselors--pointing out the sensitive issues that men are likely to face in counseling women clients and suggesting methods of acquiring the self-understanding, knowledge, and skill needed.

ISSUES NOT ADDRESSED AS SEPARATE CHAPTERS IN EITHER VOLUME

Several topics important for comprehensive programing for chemically dependent women have not been addressed directly in these chapters. Although prevention of drug dependency is not discussed in a separate chapter, implications for prevention will be apparent in many of the chapters. Moreover, several of the chapters relate directly to prevention programing (in volume 1, vocational rehabilitation--chapter 8, and parenting training--chapter 11; and in volume 2, health promotion, women's groups, survival skills, assertiveness training, and sexuality training).

Another area is pregnancy and the complex issues involved in neonatal addiction--diagnosing and treating the pre- and postnatal needs of the woman who is both pregnant and drug dependent and the child who may be born addicted. This omission occurred partially because other resources are available in this area (e.g., Finnegan [1979] and the burgeoning literature on the fetal alcohol syndrome [FAS]), and little information is now available on managing pregnancy and neonatal withdrawal from drugs other than opiates. The other reason is that for years the literature on chemical dependency has paid attention to a woman's problems only when she was pregnant, as if she is important only when she is bearing a child. The editors of this book wished to emphasize that women are important in their own right, and not just when they are mothers. Of course, many are mothers and this is an important role, so a number of chapters have been included that address the needs of women in relation to their children ("Childcare Support Services for Female Clients in Treatment" and "Parenting and Child Services for Drug Dependent Women," chapters 10 and 11 in this volume, and others in volume 2).

A third area not addressed as a separate chapter involves the management practices needed to develop and implement quality services for women. Changing established patterns and programs is difficult, especially during times of shrinking resources. In addition, some changes require a reorientation of program philosophy and approach. Program staff and management must rethink long-held assumptions about both gender and treatment for drug dependency. Staff with different knowledge, skills, and orientations must be integrated with those traditionally employed in drug and alcohol programs. Programs must interact with a broader range of other human service agencies and regulatory agencies. Change is not easy, and to be successful requires high levels of sensitivity, skills, and commitment on the part of the administrators, staff, and clients.

Women also continue to be outnumbered substantially by men in most drug and alcohol treatment programs (National Institute on Alcohol Abuse and Alcoholism 1979a; National Institute on Drug Abuse 1980). Members of any subgroup (in this case, women) that represent a small proportion of a social system (in this case, a treatment program) are subjected to "token" dynamics, which often leads to stereotyping and more social isolation within the program (Kanter 1977a,b,c). This dynamic is difficult to manage and can be a substantial barrier to providing useful services to women. Sensitivity to likely stereotypes and accurate knowledge about chemically dependent women and how they are similar to, and different from, men is especially important under these circumstances.

Many chapters in these volumes contain knowledge that should help the program manager. One key management concern, staff development and training, has been addressed in almost every chapter. Other management issues will also be apparent, e.g., developing community linkages with different sets of referral sources and sources of services.

Finally, outreach and casefinding activities for women are important for any program to consider as it assesses its services for women. As Sutker notes in chapter 2 in this volume, there is continuing speculation that many drug dependent women who need treatment are not currently enrolled in drug dependency treatment programs.

The Liepman chapter in volume 2 presents one important approach to outreach. Many others are possible, however, as counselors and managers begin to understand more about who chemically dependent women are and what they need. In fact, there is increasing evidence that the addition of services for women attracts women into treatment for chemical dependency who would otherwise not be there (Naierman et al. 1979; National Institute on Alcohol Abuse and Alcoholism 1979; Reed and Leibson 1981; Schultz 1977). Thus, by implementing suggestions contained in various chapters in these volumes, program staff will interact with and educate those in a position to identify and refer women into treatment for drug dependency. Also, as services for women improve, women served well by a program will bring others into treatment with them.

SOME FINAL THOUGHTS

The chapters included in these two volumes integrate research data, clinical experience, and practical information and suggestions in a wide range of areas important in the treatment of drug dependent women. The chapters were developed to address an ongoing problem within drug dependency treatment programs--inadequate services for women--despite the attention given to identifying the needs of drug dependent women and how best to meet them over the past 10 years. General use and application of new knowledge and research results often is a slow process in all fields, at least partially because the knowledge is not packaged in ways easily understood by those in a position to use it. Whether these volumes succeed in conveying available knowledge about chemically dependent women to those who must use it (treatment program staff) will depend at least partially on how well the authors inspire readers to implement some of their ideas and suggestions.

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Implementing these chapters in programs across the Nation will take effort and trial and error, to adapt knowledge and suggestions into a range of different programs and settings. The volumes are intended as references for those in a position to implement some of the services described. It is hoped they will be used by those who read them so that the next wave of new information and program models evolve from this use, and treatment programs become more able or willing to provide the services women need in effective ways.

Readers are also likely to find that as they work to develop better services for women they also will develop better services for all clients. Many of the problems drug dependent women and men bring into treatment are consistent with their socialized gender roles, but are in many ways caricatures of traditional female and male roles. They consist of many of the expected "feminine" or "masculine" behaviors carried to an extreme degree. As program staff become more and more aware of these patterns and work to provide their women clients with less limiting alternatives, assumptions about appropriate interventions for men may be questioned also.

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2.

Drug Dependent Women

An Overview of the Literature

Patricia B. Sutker, Ph.D.

This book was written at a time of exciting discoveries about women, their life changes and sexual cycles, their problems in society, and their unique needs. This growing interest in women's issues has led to examination of the stereotypes attributed to women who misuse chemical agents and to increased awareness of the complex nature of female drug abuse. During the 1970s, numerous clinical and research studies were directed toward women drug abusers and their problems and needs. Published articles have addressed sex-specific problems of women who abuse drugs and provided direction for improved courses of therapy and prevention strategies. Researchers have also examined factors contributing to female criminal and other antisocial behavior often associated with illicit drug use.

Before 1970 few serious attempts were made to understand social deviance (including drug and alcohol abuse) among women. Concern and disdain were expressed toward women who deviated from expected sex-role patterns (Klein 1973). Alcoholics, addicts, and other women who deviated were typically viewed as more maladjusted than were men with similar behavioral aberrations. Sometimes female deviants were pitied and protected as victims of their own helplessness and dependence; sometimes they were punished for having strayed so far from societal expectations.

Challenging basic assumptions about women and social deviance, Pollak (1950) argued that women were more involved in criminal activities than was apparent but were less likely to be detected, arrested, or convicted for illegal acts. Inherent in this proposition is the notion that female criminals and social deviants are no less moral or immoral than men engaged in similar activities. Rather, women have fewer opportunities for social deviance than men do and are less likely to be detected and punished for engaging in crminal activities. The extent to which this line of reasoning is mirrored in societal attitudes and behavior is open to question. Feminists demand that women be regarded more objectively and be "removed from the pedestal," so to speak, while other female groups are equally adamant that to do so would rob women of their rightful, protected position. For American women, divided by factors of economics, values, and age, it will not be easy to resolve these issues and determine their problematic implications for treatment.

Although the increasing use of drugs in American society was recognized in the 1960s, articles on drug misuse and dependence among women were slow to appear compared with those written about men. As several social scientists observed, the special problems and needs of women addicts received little attention until the mid-1970s (Eldred and Washington 1975; Maglin 1974; Waldorf 1973). This absence of investigatory activity and knowledge, in combination with the attitudes described above, led to assumptions that women had less need of or were less amenable to drug abuse treatment than were men. In part, lack of interest in female drug abuse was attributed to a predominance of male illicit drug users and their greater visibility.

Pointing to the treatment needs of chemically dependent women, Schultz (1975) decried male-dominated drug abuse treatment programs, approaches, and institutions and argued that women's needs were either largely ignored or misunderstood. Indeed, many articles written in the early 1970s that described the problems and crises common to women drug abusers focused on a lack of concern for women and even that women were exploited in drug abuse treatment programs. Davidson and Bemko (1978) noted significant changes in the content and focus of published papers dealing with drug abuse problems among women from 1966 to 1975. Early publications contained little information on the epidemiology of female drug use and abuse, comparisons of male and female opiate addicts on psychosocial dimensions, descriptions of incarcerated female drug abusers, and problems related to female reproductive physiology and functioning. By 1974, 50 percent of the published articles on women and drug abuse addressed specialized areas of female concern, such as mother/infant interactions, coping skills, and treatment and vocational needs.

The literature has reflected increasing sensitivity to sex-specific interpersonal and biological problems, social changes brought about by the women's movement, pressures exerted by these changes, and a growing awareness of the extent and complexity of drug abuse problems among various female subgroups. As evidenced by this book, the use patterns, psychosocial characteristics, and sociomedical needs of women who misuse or become dependent upon licit or illicit drugs have become important targets for research study, clinical speculation, and therapeutic intervention.

This chapter has three sections. The first focuses on changing patterns of illicit and licit drug use, motivating factors for drug use, and differences in these patterns among men and women. This section presents information on the ways that person characteristics such as gender, age, and ethnicity, in interaction with environmental variables, are related to patterns of licit and illicit drug use.

The second section examines research findings that describe characteristics of chemically dependent women--their early social histories, employment statistics, physical and psychological attributes, criminal behavior, interpersonal relationships, and responsibility for children. Emphasis is given to the complex interplay of person characteristics and environmental factors that influence the behavior of women.

The last section focuses on treatment issues, including the specific problems, needs, and conditions faced by women entering treatment. This chapter highlights and integrates some of the findings which form the basis for the chapters that follow.

PATTERNS OF DRUG USE

A comprehensive description of the drug use and abuse patterns of women compared to those of men is beyond the scope of this chapter. In general, the data to be summarized show that men are more involved with illicit drugs, whereas women are more likely to use licit drugs, although some studies show that the patterns are converging. Generalizing about drug use patterns among women, however, can obscure differences that have important treatment implications. Although licit and illicit drug use are often associated and may occur for similar reasons, society has historically been more concerned about illicit drug use and related lifestyles. Thus, licit and illicit drug use are discussed separately in the following sections.

ILLICIT DRUG USE PATTERNS

Certain drug-taking practices were defined as illicit in the United States following the passage of the Harrison Narcotics Act in 1914. Prior to this legislation, opiates could be obtained without prescription for physical and psychological maladies. Estimates at the time the act was passed indicated that twice as many women as men were opiate dependent (Chein et al. 1964; Terry and Pellens 1970). As opiates came under legal censure, the population of regular users took on a different composition, and the number of women declined significantly (Cuskey et al. 1972). Reviews of female abuser characteristics and patterns published by Christenson and Swanson (1974), Prather and Fidell (1978), and Suffet and Brotman (1976), identified other changes in use patterns related to gender.

In recent years, data on illicit use patterns have been derived from a variety of sources, including surveys of household respondents, high school students, clients in treatment, and prison inmates, and from hospital emergency room and health service records. Sources of data describing drug abuse behavior are limited by the populations they represent, and countless abusers remain hidden.

According to Prather and Fidell's (1978) review of the literature, women's use of heroin, marijuana, and other psychotropic drugs has been increasing. These researchers concluded that heroin addiction has increased at a faster rate for women than for men, that in some areas of the United States women's use of marijuana is estimated to equal that of men, and that use of psychotropic drugs is consistently higher among women. Evidence suggests that women still use significantly fewer illicit drugs, such as heroin, cocaine, hallucinogens, inhalants, marijuana, and other nonmedical substances, than do men (Chambers and Brill 1971; Chambers and Schultz 1971; Johnston 1968; Manheimer et al. 1969); however, the rate at which new cases of addiction are identified is now greater among women (Chambers and Hunt 1977). Findings of the National Survey on Drug Abuse, a household survey conducted by the Social Research Group, George Washington University, showed that young men, aged 18 to 25, are more likely to be involved in illicit drug use than young women (Fishburne and Cisin 1980). Surprisingly, lifetime prevalence differences in marijuana use were not striking (61 percent of young women and 75 percent of young men reported having used marijuana). However, young men who reported marijuana use were more likely than young women to be frequent users of the drug.

In an earlier national survey, Abelson et al. (1977) reported that much higher percentages of men as compared with women reported lifetime nonmedical use of prescription sedatives (8 percent vs. 4 percent), tranquilizers (7 percent vs. 3 percent), and stimulants (11 percent vs. 6 percent). The disparity among male and female adolescents (12 to 17 years of age) was much less. Data from a national survey of high school seniors (Johnston et al. 1980) also showed little difference in the percentages of young male adolescents and females using prescription drugs. Nonmedical use of tranquilizers and stimulants was slightly greater for female students, whereas males were more likely to use marijuana, cocaine, hallucinogens, and opiates. Similar findings on adolescent drug use were reported by Paton and Kandel (1978) and Blackford (1977).

In examining treatment data from the Client Oriented Data Acquisition Process (CODAP), a national reporting system developed by NIDA for all federally funded treatment units, Rosenthal et al. (1979) found that the primary drug of abuse at admission to drug abuse treatment differed by gender. A higher percentage of men used opiates, and women were almost twice as likely to be abusers of barbiturates and sedative/hypnotics. More recent CODAP data (National Institute on Drug Abuse 1980a), however, indicate that the differences in drug use patterns are diminishing. Heroin was the most frequently reported primary drug for both women and men admitted to treatment programs in 1979--38 percent of all women clients and 41 percent of males.

Data from CODAP (National Institute on Drug Abuse 1980a) also show that the primary drug of abuse at admission is related to race or ethnicity and age. Among women clients, opiates accounted

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for 70 percent of black admissions, 65 percent of Hispanic admissions, and 35 percent of white admissions. The 25- to 29-year-old age group had the highest percentage of opiate admissions for all three populations. Admissions for tranquilizer abuse were particularly frequent among white women over 29 years old (19 percent). Research conducted by Sutker et al. (1978) and the work of Kaestner et al. (1977) also indicated that ethnicity is significantly associated with specific patterns of illicit drug use. Blacks in treatment report use of fewer different types of drugs, show preference for depressants over stimulants, and use drugs at older ages than do similar groups of whites. Reed et al. (1980) reported that black women were more likely to say they use heroin only or heroin and recreational drugs such as marijuana and cocaine. White women, however, report the use of other opiates or heroin and nonopiate (largely prescription) drugs.

Thus, the evidence suggests that illicit drug abuse patterns can change quickly and are influenced by a variety of environmental factors. Although certain patterns can be identified with reliability for a given time, place, sample, and situation, illicit drug patterns will vary as a function of person and environment factors, including the relatively unalterable characteristics of gender, ethnicity and age, and the sociocultural milieu in which drugs are taken. In all age groups, men are most likely to seek help at crisis centers for problems associated with heroin, marijuana, hallucinogen, and barbiturate use. Women most often seek treatment for complications related to heroin and psychotropic (prescription) drug use (Burt et al. 1979). Analysis of drug abuse treatment data shows that male clients tend to be more evenly distributed across age brackets, whereas women are more heavily concentrated in lower and middle age groups (Chambers and Hunt 1977).

LICIT DRUG USE PATTERNS

Women exceed men in the use of prescribed drugs, a fact well documented in the literature (Abelson et al. 1977; Cooperstock 1971; Parry et al. 1973). Sampling a cross-section of households (including more than 2,500 adults), Parry et al. (1973) found widespread medical and nonmedical use of prescription and over-the-counter (OTC) agents among women and men. Current prevalence rates for women were more than double those for men, with sedatives (including minor tranquilizers) and stimulants accounting for most of the difference. Type of drug used, age, geographic region, educational level, and socioeconomic class were among the factors cited as related to drug-taking patterns. Contrary to common belief, chronic ingestion of prescription sedatives and minor tranquilizers was more prevalent among poor and less educated women than among middle-income women.

Survey data also show differences in licit drug use patterns as a function of age and gender. For example, psychoactive drug use was found to occur most extensively among men in the youngest and oldest groups, whereas women averaged 14 percent higher use rates across ages. Other trends indicate that men tend to use stimulants in their teens and twenties, minor tranquilizers during middle age, and sedatives in the elderly years. Women, however, tend to use all of these drugs at greater rates than men across all age categories. The Drug Abuse Warning Network (DAWN), a Federal monitoring system that reports drug-related admissions to hospital emergency rooms and deaths recorded by medical examiner's offices, showed that women have a comparatively high rate of mentions[1] of tranquilizers and nonbarbiturate sedatives (National Institute on Drug Abuse 1980b). Women accounted for 72 percent of the emergency room (ER) mentions and 57 percent of the medical examiner mentions for flurazepam in 1978. Moreover, for diazepam, women accounted for 65 percent of the ER mentions and 47 percent of the medical examiner mentions.

Use of sedative/hypnotics among women is strongly associated with high rates of emergency room (ER) and medical examiner contacts as compared with those recorded for men (National Institute on Drug Abuse 1980b). Although these figures do not necessarily describe a homogeneous population of regular psychoactive drug users, they do reflect an association between life-threatening complications and nonmedical use of tranquilizers, nonnarcotic analgesics, barbiturate and nonbarbiturate sedatives, alcohol, and drugs in combination that differs by gender, age, and ethnicity. Supporting this conclusion are the findings of Burt et al. (1979) which show that considerably more ER contacts for psychotherapeutic drug problems occurred among women than men and that nearly twice as many female as male contacts with ER facilities were diagnosed as drug overdose. Data from the medical examiners collected in 1979 as part of the Drug Abuse Warning Network (National Institute on Drug Abuse 1980b) showed that 48 percent of all drug-related deaths occurred among women, most of whom were over 35 years old.

MOTIVATING FACTORS BY DRUG USE

In some ways, prescribed psychoactive drug use and illicit drug use are alike in that they may both serve comparable functions for women at different stages in the life cycle or for different social groups at the same stage (Kandel et al. 1981). There have been numerous attempts to isolate possible motives for initial and sustained drug use and to describe the extent to which motives may vary as a function of person characteristics. Naditch (1975) identified self-medication, curiosity or pleasure, and peer pressure as primary motives for drug use among predominantly young, white, male adults. Whether such motives are evenly distributed by ethnic group and gender among drug abuser categories remains an area for study. However, reasons cited for initiating opiate use have generally been the same for men and women, that is, for pleasure, curiosity, and peer acceptance (Chein et al. 1964; Ellinwood et al. 1966). Sutker et al. (1978) found that among chronic illicit drug users, neither gender nor ethnicity was significantly associated with reason for the first use of drugs or alcohol. Women and men were just as likely to seek out new and exciting experiences, and both groups scored high on self-report measures of sensation-seeking tendencies.

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[1] Drug mentions represent the sum of all substances, in the aggregate, that played a part in causing a person to require treatment at a hospital emergency room or to be associated with his or her death as reported by the medical examiner.

Recently, more attention has been given to the strains and stresses which women may encounter associated with their expected social roles as well as to the coping mechanisms marshalled to counteract such pressures (Kandel et al. 1981). Socialization experiences, views of women in society, and career option limitations for women may lead to feelings of dependency, lack of control, being unable to change one's life circumstances, and social isolation. Drug use is seen as a symptom and as a potential coping mechanism to counteract the pressures that arise and may, in turn, become another source of stress.

Differences in the way that males and females obtain drugs are also relevant to the study of drug use motives. Suffet and Brotman (1976) suggest that gender differences occur in the process of being introduced to drug use. Women were more likely to have been first exposed to drugs by men, whereas men were found to introduce each other to drug use. Women most often obtained psychotherapeutic drugs from physicians, whereas men usually purchased psychotherapeutic agents on the streets or used alcohol instead (Mellinger et al. 1971; Parry et al. 1973). A study of treatment clients showed that women are becoming increasingly independent in seeking out and obtaining drugs, in taking responsibility for drug use, and in engaging in independent drug-related criminal activity (Moise et al. in press).

Growing evidence shows that the choice of different substances for coping is socially determined and is different for men and women (Kandel et al. 1981). The more frequent abuse and misuse of prescription drugs by women has been linked to feelings of distress and illness (Chambers and Griffy 1975; Cooperstock 1971; Mellinger et al. 1978; Parry et al. 1973), physician prescribing practices (Cooperstock 1971; Fidell 1977; Wesson and Smith 1977) and the unavailability of treatment alternatives (Borgman 1973; Mayer 1975; and Sellers 1978). Cooperstock (1971) proposed that women may be more open in expressing their emotional concerns and in bringing their problems to the attention of physicians.

Hospital emergency room data produced by DAWN (National Institute on Drug Abuse 1980b) show that men and women tend to have different motivations for taking drug overdoses. Women are far more likely than men (49 percent vs. 26 percent) to cite suicide attempts or gestures; men's reasons are more evenly dispersed among psychic effects, dependence, and suicide attempts or gestures.

Abelson et al. (1973) found that for "coping," men were more likely to use alcohol and women were more likely to use psychotherapeutic agents.

CHARACTERISTICS OF DRUG DEPENDENT WOMEN

Any attempt to characterize drug dependent women as a group will be, of necessity, an overgeneralization. Nevertheless, an examination of distinct drug abuse problems among women as a group is necessary to understand general patterns and to plan appropriate intervention strategies. Researchers and clinicians have attempted to describe isolated samples of chemically dependent women, e.g., heroin addicts, sedative/hynotics users, alcoholics, and multiple-drug users. Conceptually, much of this work is built upon underlying assumptions that chemically dependent individuals are both decidedly different from those who do not misuse chemicals and basically deficient as persons. As in studies of criminal offenders, researchers have sought to identify negatively viewed personality characteristics (often in association with childhood trauma, poverty, or other crisis) that are assumed to precipitate and sustain socially nonsanctioned behaviors. Although this approach was often based on judgmental values and assumptions, it constituted a beginning for research investigation and clinical focus. With time, researchers are learning to resist tendencies to conceptualize drug abuse as a unitary phenomenon prompted by simple causes or maintained by unitary factors.

As subgroups of chemically dependent women are studied, researchers should examine value systems, intuitive assumptions, and research methodology to assure consideration of person and environment factors as well as the strengths and assets of drug-abusing women and men. As Nathan and Lansky (1978) suggest, the literature supports the need for a sophisticated view of chemical dependence, based on assessments of complex individual systems interacting with personal history and environmental factors. Although some degree of oversimplification is useful, we must continue to strive to discover the unique characteristics specific to subgroups of women and their psychosocial situations.

EARLY SOCIAL HISTORY

Many theories emphasize the role of childhood events and family life in the genesis and persistence of substance abuse. Researchers have cited family illness, family disruption by parental death or separation, marital disharmony, modeling of parental nonconformity, alcohol and drug abuse, and high rates of physical and sexual assault as characteristic of the early family history of women who abuse drugs or become alcoholics (Chambers et al. 1970; Chein et al. 1964; Raynes et al. 1974; and Schuckit and Morrissey 1976). High incidence of childhood personal trauma has been reported among opiate-dependent women (Aron 1975; Benward and

Densen-Gerber 1975). Most research on this subject, however, is striking by the absence of any kind of control group. It is rare to find a control group of comparable class, culture, and environment with the drug-abusing sample.

In what is now considered a classic study, Chein et al. (1964) compared the families of addicted men with other families in the same geographical areas and found significantly more problems and disturbances in families of the addicted men. Although this study had no control group for the small number of addicted women included (N=20), the families of these women appeared similar to those of the addicted men, and thus, presumably, they would also be different from the average family in the area. Data collected by the Women's Drug Research Project, however, suggested only minor differences in family background between addicted women entering treatment and controls from the same geographical area (Binion 1979).

It has also been suggested that women drug abusers tend to come from more disturbed families than do male drug abusers (Moise et al. in press). One study found that families of addicted women, both blacks and whites, could be characterized by different kinds of family distress, with black women experiencing less family compatibility (Waldorf 1973). In the case of alcoholism, Beckman (1976) described female alcoholics as being frequently exposed to parental loss and emotional trauma and coming from families with cold, domineering mothers, alcoholic parents, or minimal parental training in morality.

INTERPERSONAL RELATIONS

Many women addicted to opiates are more likely than men to cope alone, and they have fewer social networks than either addicted men or nonaddicted women. Waldorf (1973) concluded that opiate-abusing women had many more problems than men in relating to others. Tucker (1979) reported that the addicted women in her study were less likely than men to use social strategies to cope with unpleasant emotions. They were more likely to isolate themselves and to take drugs when depressed, whereas addicted men were more likely to talk about their feelings with wives and girl friends.

The Women's Drug Research Project (WDR) found that one-third of the black men in its sample and one-fourth of the white men were living with women who were not abusing drugs; these figures compare with 15 percent of the black women and only 7 percent of the white women living with men who were not abusing drugs (Ryan and Moise 1979). Men were also more likely than addicted women to be living with a legal spouse. Studies have also shown that addicted women maintain ties with members of their family or origin, live near them, and often rely on their mothers for support (Tucker 1979; Wallace 1976).

The WDR studies suggest that many addicted women fail to use available community agencies and resources (Reed and Leibson 1981) and rarely seek professional services prior to entry into drug treatment. Reed and Moise (1979) concluded that addicted women, even more than other women and addicted men, have learned to value male and devalue female roles and behaviors. These women often feel that there is a barrier between themselves and "normal" women because of their addiction. Study findings indicate that chemically dependent women are less comfortable with members of their own sex than are nonaddicted women, and they hold more traditional concepts of appropriate feminine behavior (Baldinger et al. 1972; Colten 1979; Miller et al. 1973; and Wilsnack 1973). Addicted women tend to see themselves as emotionally stronger than addicted men, yet, paradoxically, they report needing men for protection and survival in society (Colten 1979; File 1976).

CHILDREN OF DRUG DEPENDENT WOMEN

Colten (1980) explored maternal concerns among drug-abusing women by comparing groups of heroin-addicted women in treatment with nonaddicted controls. Women addicted to opiates were found to have terminated marriages and given up their children more often than nonaddicted mothers. Addicted women, however, were found to want and have children for reasons similar to those of nonaddicted women, but they also reported being less strict, less physically punitive, more fearful about their children's futures, and less sure of their adequacy as mothers.

Statistics available on the children of opiate-abusing women (Eldred and Washington 1975; Gerstein et al. 1979; Reed and Moise 1979; Suffet and Brotman 1976; Wasnick et al. 1980) show that 60 to 70 percent of women entering drug treatment programs have children. Approximately 50 percent of the children were living with their addicted mothers at the time of entry. Percentages are higher among black women (70 to 80 percent have children; 60 percent have children living with them) and somewhat lower among white women (50 percent have children; 30 percent have children living with them). Researchers have noted that women in treatment are far more likely to have responsibility for dependent children than do male clients (Eldred and Washington 1975; Reed and Moise (1979).

Sowder and Burt (1980) reported that a substantial number of the children of addicted mothers in their study were at high risk for child abuse. Based on clinical experience, Densen-Gerber and Rohrs (1973) contended that dependence on illicit drugs and provision of adequate child care are generally incompatible. Difficulties in parenting result in great stress for drug-dependent women as well as for their children (Lief 1977). Research has also raised questions about the extent to which responsibility for childcare limits a mother's ability to participate successfully in treatment.

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In part, perhaps, because of isolation and lack of support, addicted women have difficulty coping with anger and other emotions, and they often fear expressing these feelings to their children (Tucker 1979). Child abuse has been associated with chemically dependent women, although it has been found that the extent of the problem may be overstated (Lief 1977; Ryser et al. 1975). Studies also have shown that children are an important part of the addicted woman's life and are likely to become more important as she finds new sources of satisfaction and increased self-esteem (Colten 1979; Eldred et al. 1974; Milstein et al. 1971).

Burt et al. (1979) point to treatment data that show that higher percentages of female than male drug treatment admissions are under 21 years of age. The children of addicted women, therefore, tend to be young. In comparing children of addicted parents with children of nonaddicted parents from the same neighborhood, Sowder and Burt (1980) report that addicted women spent less time with their children. The children of addicted parents were also found to experience more academic problems.

EMPLOYMENT

Most women entering treatment for drug abuse are unemployed and have not worked in the year prior to treatment. This is usually the situation regardless of whether the primary drug of abuse is heroin, tranquilizers, marijuana, sedatives, or amphetamines (National Institute on Drug Abuse 1980a). Numerous investigators have reported high rates of unemployment among women who abuse illicit drugs--e.g., 81 percent (National Institute on Drug Abuse 1980a), 82 to 87 percent (Suffet and Brotman 1976), 89 percent (Eldred and Washington 1975), and 96 percent (Gioia and Byrne 1975). These women often have failed to develop marketable skills or experience outside the deviant subculture, and most have not completed high school education (e.g., Driscoll and Barr 1972; Eldred and Washington 1975; Gioia and Byrne 1975; Reed and Moise 1979; Suffet and Brotman 1976). Moreover consideration must be given to the high probability that the woman addict will be a single parent with one or more dependent children.

Unemployment remains one of the most difficult problems to resolve; approximately 72 percent of the women who terminate treatment are unemployed (National Institute on Drug Abuse 1980a). It is not surprising then that some investigators (Gioia and Byrne 1975; Levy and Doyle 1974) report that drug-abusing women cite career training and development activities (employment and education) as the most important treatment services.

PHYSICAL AND MEDICAL PROBLEMS

There is evidence that women are physically ill more often than their male counterparts (Roskies et al. 1975; Uhlenhuth et al.

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1974; Uhlenhuth and Paykel 1973). Investigators have focused on the physiological disturbances that occur as precursors to, result from, or are associated with drug abuse and concomitant lifestyle patterns. Physical and psychological complications tied to the female menstrual cycle are described by Moos and his collaborators (Moos 1968, 1969, 1977; Moos and Leiderman 1978). Changes in somatic and mood states have been implicated as factors in the etiology of alcoholism and drug dependence. For example, Podolsky (1963) and Belfer et al. (1971) suggested that premenstrual and menstrual tension and depression may be associated with heavy drinking.

Some investigators have reported that drug-addicted women who enter treatment programs also tend to have more medical problems and complications than do chemically dependent men (Andersen 1977, 1980). One study (Tucker 1979) showed that 75 percent of women entering drug treatment reported having health problems, compared with 41 percent in a comparison group of nonaddicted women and 58 percent of addicted men. In addition, Andersen found that 43 percent of the women admitted into drug treatment had gynecological problems. Dysmenorrhea is particularly common among opiate-abusing women, and they are at risk for gynecological problems and infections (Gossop et al. 1974; Santen et al. 1975; Stoffer 1968).

Female physical complications associated with chronic drug abuse may also interfere with reproductive physiology and functioning. As Finnegan (1979) noted, most women who abuse drugs are of childbearing age, and the potential seriousness of drug use during pregnancy has only recently been recognized. Female drug abusers are often troubled by gynecological complications, venereal diseases, urinary tract and bladder infections, and menstrual irregularities. Complications with pregnancy and child delivery are also associated with chronic use of alcohol, barbiturates, opiates, nonnarcotic sedatives, and tranquilizers (Apgar 1964; Athinarayanan et al. 1976; Bleyer and Marshall 1972; Rementeria and Bhatt 1977; Sokol 1979). Densen-Gerber et al. (1972) pointed out that frequent sexual activity, lax methods of birth control, and unexpected pregnancies increased the risk of physical complications and resultant problems among young female drug abusers.

PSYCHOLOGICAL CHARACTERISTICS

One of the earliest comparisons of psychopathology between male and female drug abusers was conducted by Olson (1964) who explored responses on the Minnesota Multiphasic Personality Inventory (MMPI) in 120 institutionalized addicts. In this study, men were hospitalized for drug abuse problems and women were incarcerated. Women were found to show significantly higher scores on scales indicating depression and suspiciousness. Both groups were characterized by exaggerated social deviance, and the published composite profiles for each gender group were remarkably similar.

More recently, Jainchill and DeLeon (1979) undertook similar comparisons using a variety of psychological measures. Data were interpreted to support the premise that women were more likely to show signs of depression, anxiety, and maladjustment than were men in a therapeutic community treatment setting. Further, an investigation by DeLeon and Jainchill (1980) across seven therapeutic communities (TC) showed that women in this treatment modality were characterized by higher levels of emotional disturbances, more psychosomatic symptoms, and lower self-esteem than male clients.

Using the semantic differential format for addict-client ratings of concepts of self and ideal self, Gossop (1976) found that women were characterized by lower feelings of self-esteem. Similarly, Miller et al. (1973) reported that female addicts were more preoccupied with such values as cleanliness and self-respect than were men and that this possibly reflected their exaggerated feelings of dirtiness and worthlessness associated with lifestyle and drug-related experiences. In a study by Deren and Koslowsky (1977), women addicts scored significantly higher than men on the Sixteen Personality Factor Questionnaire (16PF) measures of dependency, conscientiousness, apprehension, suspiciousness, social awareness, and tension.

In contrast to the reports described above, other investigators have reported that male and female heroin addicts differ little in extent or type of psychopathology. Berzins et al. (1974) as well as Weiss and Russakoff (1977) reported that similarities in personality characteristics between the sexes were far more striking than differences, at least among hospitalized heroin addict samples. Further, comparisons among drug abusers who applied for multimodality treatment programs in two geographic locations showed that women were more open than men in admitting personal faults and psychological problems and less inhibited in the expression of social deviance; yet neither gender group could be said to be more psychopathological in reference to their normative sex group than the other (Sutker et al. 1980). Similarly, when interrelationships among gender, race, drug use patterns, and personality variables were examined among chronic users of illicit drugs undergoing treatment, drug use and personality patterns among women were found to differ little from those of men (Sutker et al. 1978, in press).

Women and men also showed few dissimilarities on sensation-seeking measures, with both groups reflecting exaggerated needs to seek out new and exciting experiences. Hence, although women and men may differ in terms of their needs for therapeutic focus, the statement that female drug abusers are psychologically "sicker" than male drug abusers cannot be concluded from these findings.

CRIMINAL BEHAVIOR

Lifestyle and career patterns for maintaining illicit drug abuse have been studied extensively for male addicts (Preble and Casey 1969). Similar research has only recently been undertaken for female drug abusers. According to the literature, most women who abuse illicit drugs are involved in illegal activities and have been arrested at least once (Chambers et al. 1970; Driscoll and Barr 1972; Inciardi and Chambers 1972; Levy and Doyle 1974). Studies show that the most frequent criminal charges made against drug-abusing women are nonviolent property offenses, followed by drug dealing and prostitution (File et al. 1974; Inciardi and Chambers 1972; Sutker and Moan 1972). Given the nature of these types of crimes and a general leniency with women, the criminal justice system puts less pressure on drug-dependent women than on addicted men to obtain drug treatment services (Schuckit and Morrissey 1976).

In investigating sex-role differences in criminal activities associated with illicit drug use, File (1976) concluded that shoplifting and prostitution were common among women, whereas men more frequently relied on robbery, con games, and burglary to support their drug use. James et al. (1979) studied relationships between female criminality and drug use patterns among four groups: addicts, prostitute-addicts, prostitutes, and offenders. Addicted women admitted that most of their income was derived from reselling drugs and from prostitution, whereas female offenders more often reported income from drug sales, shoplifting, and larceny. It was concluded that female offenders of all types, like their male counterparts, gravitate to criminal activities which are most suited to their skills, represent relatively low risks, and yield satisfactory and quick returns. For all groups studied, drug use became an integral part of an antisocial lifestyle and was supported by illegally obtained funds.

Finally, as other investigators have pointed out, the roles and activities of drug abusers are neither stable nor mutually exclusive. Female criminal activity associated with drug abuse may change as women receive more career opportunities and assume new roles and responsibilities. This trend is reflected in data reported by Simon (1975), who found sharp increases in the number of women convicted for drug law violations and forgery in California and Ohio.

TREATMENT ISSUES

Women drug abusers have been at a disadvantage on entry to treatment programs. Staff and other clients often view women in drug abuse treatment more negatively than they view men, and their sex-specific social and biological needs are often misunderstood or ignored. Women are as frequently troubled by legal difficulties as are their male counterparts. Further, women drug abusers require more assistance with childcare, marital, and vocational problems.

Treatment outcome, of course, will vary depending on the characteristics of the treatment program, the client, the therapist, methods of therapeutic intervention, and other variables, many of which are not adequately specified or quantified. As noted by Emrick (1975) and McCord (1978), the matter of assessment of treatment outcome and client success is complex, whether for drug abuse, psychiatric, or other patient populations. Nevertheless, knowledge gained over the past decade from research on women and their special problems can be applied to improve drug abuse treatment services for both sexes. For example, identified sex-specific needs of female drug abusers have become important targets for description and treatment application. It is now known that programs for female drug abusers must attend to women's biological needs; manage their psychological problems; assess and ameliorate concerns related to vocational, family, and childcare issues; and work to reduce sexism in planning therapeutic strategies. These gains have obvious benefits for both male and female drug abuse clients.

Because women drug abusers are potential or actual mothers, their medical problems have significance for the progeny of society. As Finnegan (1979) noted, most women who abuse drugs are in their child-bearing years, and the seriousness of drug use during pregnancy is only now becoming fully appreciated. Women drug abusers often are troubled by medical problems and complications and therefore require thorough initial physical examinations, sustained treatment for identified health problems, and counseling regarding disease prevention applicable to themselves and their potential offspring (see chapter 6).

In addition, medical complications may result when addicted women have unexpected pregnancies. Densen-Gerber et al. (1972) draw relationships between rates of unexpected pregnancies and women's low levels of self-esteem, exaggerated needs for feelings of belonging, and search for female identity. Statistics from Odyssey House, Inc. (Densen-Gerber et al. 1972) also indicate that a significant percentage of the women residents have been victims of incest and other forms of child abuse. Arguments that women are subjected to greater shame and alienation than are men follow from a logical standpoint, and research results indicate that female abusers are more aware of feelings of self-esteem than are males. The possibility that women show greater tendencies toward depression, its open expression, or self-degradation must be considered in treatment planning.

Studies of emergency room contacts and suicide attempts show that women are more likely than men to present drug overdose problems. In particular, women over 35 years old are at high risk for abuse of psychoactive medications and intentional or unintentional overdose (National Institute on Drug Abuse 1980b). Research must still address whether depression and low self-esteem play roles in the etiology of chronic drug abuse and overdose sequelae.

With sweeping changes in societal norms for sex-specific expectations, both men and women require assistance in dealing with their concepts of self and those aspects of self and others that may be categorized as masculine, feminine, or androgynous. Among the more practical problems of survival for women drug abusers are those of educational achievement and vocational placement. In general, women tend to be less well employed, educated, and compensated for their work than men. It is not surprising then that female drug abusers have experienced less success than their male counterparts in maintaining employment and achieving vocational advancement. Women in society remain in less advanced or status-related jobs than do men, and even professional women tend to receive lower salaries for the same work. Therefore, from a therapeutic standpoint, it is important for treatment specialists to shed prejudices against educational and employment advancement for women and relinquish other sex-role stereotypes regarding personal and professional priorities for women. As noted by Levy and Doyle (1974, 1975) women are less likely to be considered for vocational advancement in drug abuse treatment programs, whereas career goals are more seriously developed for male clients.

Some social scientists have speculated that women drug abusers come from more disturbed family settings than do men drug abusers. In all probability, both men and women who abuse drugs experienced similar childhood difficulties in the home. Nevertheless, the heaviest burden for childcare and rearing still falls to the mother, and she must assume primary responsibility for nurturing her children. For female drug abusers, many of whom were beaten and sexually abused as children, childrearing may represent a significant challenge requiring extended training and support. Similarly, men in drug abuse treatment should be helped to develop satisfying and adaptive intimate male-female and parent-offspring interactions. Santo (1977) suggested that the genesis and maintenance of drug abuse behavior are intricately related to ongoing family processes. Although the family interaction patterns and conditions that foster drug use and dependence have not been clearly identified, there is evidence that family therapy can be a useful tool in treating chemically dependent men and women (see chapter 9, this volume).

This book will explore ways in which women's concerns can be addressed within therapeutic frameworks. Basic problems that require attention include the special biological and health needs of women abusers, such as disease prevention among women and their potential offspring, unexpected pregnancies, inadequate childcare, psychological patterns common among women, the implications of sex-role stereotyping, conceptions of masculinity and femininity, educational and vocational problems, and counseling and instruction on family interactions and interpersonal skills building.

CONCLUSIONS

This overview briefly summarizes some of the facts about drug-abusing women that have been presented in the scientific literature. Although this book will detail mechanics of service delivery, some suggestions regarding treatment will be mentioned here. The sociomedical needs of female drug abusers must be carefully assessed and appropriately addressed across treatment modalities and community agencies available for drug abusers. Women traditionally have been underserved in most treatment programs and sometimes relegated to subservient roles in therapeutic settings. Treatment program staff and clients have tended to view women drug abusers in a more negative light than they view their male counterparts, and the particular sex-specific needs of women frequently have been misunderstood or ignored. Although this book focuses on female drug abusers and their unique problems, it does not intend to ignore the special needs of men. Indeed, it is suggested that drug abuse treatment processes will achieve maximum effectiveness when members of both sexes are appropriately considered in treatment program planning. Although differences between the sexes may be identified in drug use patterns and preferences, in emotional expressions, or in antisocial pursuits, they must be used to improve therapeutic treatment, not to create further gaps between the sexes or to enhance stereotypic mentation.

Drug abuse treatment experiences for men and women must evolve in settings characterized by the absence of sexism and acceptance of the androgyny of men and women. Persons in positions of responsibility must be prepared to deal with the medical, social, and psychological problems common to both male and female addicts. Treatment programs and packages must be designed to avoid stereotyping of goals and activities for male and female clients. Both men and women should receive equal opportunities for vocational counseling and interpersonal skills building. For example, residential communities should insure that men and women share such traditionally defined duties as kitchen assignment. Both sexes should have opportunities for educational and vocational development, learn how to manage childcare and parenting duties, and prepare for greater involvement in personal health maintenance and sickness prevention activities. In addition, women should have special opportunities for group experiences to enhance female-female relationships.

Treatment personnel will be most effective when supplied with accurate facts regarding the physiological and sociocultural bases of male-female differences and encouraged toward unbiased acceptance of both sexes. It therefore will benefit treatment specialists to recruit and plan for increasing numbers of female patients in treatment programs, to assure unbiased attention to their specified needs, and to encourage their assimilation within the treatment program.

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3.

Intake and Diagnosis of Drug Dependent Women

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Intake, in this chapter, is defined as the interval between a program's first contact with a woman applicant for drug abuse treatment and the point of mutual agreement to initiate therapeutic services either within the agency or through referral to a more appropriate setting. The activities that take place during the intake process may be relatively simple or quite complex, but they involve three basic, interrelated steps:

1. Eligibility screening to determine whether a prospective client meets specified admission criteria such as age, addiction history, residential restrictions, and insurance coverage;

2. Diagnostic procedures to identify the applicant's problems and resources, to assess what needs can and should be met, and to recommend a suitable treatment regimen; and

3. Programmatic orientation and arrangements to explain treatment services and participation requirements, to insure confidentiality safeguards, and to negotiate a mutually acceptable treatment placement.

The first step in the treatment process is too vital and too precarious to be described merely in terms of routine procedures. Intake workers must simultaneously earn each applicant's trust, convey an appreciation for the pervasive and destructive consequences of substance abuse, and evoke a commitment to the hard work and mutual cooperation between client and program staff that will be necessary during the treatment process.

Designing and implementing appropriate intake procedures for women are challenging program obligations. The usual applicant for drug abuse treatment services is in the midst of personal crises and is highly ambivalent about, if not resistant to, the requirements for self-examination, revelation, and change that are implied in requesting and accepting help.

In addition to the stress created by application for treatment, women frequently face other physical, financial, and emotional obstacles that interfere with their full commitment to the therapeutic process. They may find it difficult, because of transportation and childcare problems, to get to the treatment facility; they may be afraid for their personal safety when traveling to centers located in high crime areas or in poorly lighted neighborhoods; they are more apt to be in physical pain or distress because of drug-related health problems; they may lack insurance or other funds to pay for services; and they are often reluctant, because of fear and embarrassment, to discuss pressing personal problems.

First impressions of the treatment facility can profoundly influence a prospective client's decisions about continuing treatment. The first interview sets the tone for the relationship between a program and the client. Getting off to a good start is, therefore, crucial. Insensitive intake workers and programs indifferent to women's special needs jeopardize continued and effective rehabilitation efforts.

The purpose of this chapter is to motivate and guide drug abuse treatment programs that serve women to reexamine and restructure their diagnostic intake functions and procedures in light of two recent developments:

1. Research findings on the special needs and characteristics of chemically dependent women that have implications for the services provided to them, and the sequence and manner in which these should be arranged and delivered; and

2. Improvements in service quality standards for drug abuse treatment programs that emphasize comprehensive client assessments and individualized treatment planning, thorough and systematic documentation of clinical processes, attention to the treatment environment, and use of appropriate community resources in client case management.

Because programs that serve women are located in a variety of geographic and organizational settings, offer many different types and combinations of services, and vary widely in available resources, standard intake regulations are impossible to design. No single set of questionnaires or routine sequence of activities will satisfy all variations in program philosophies or client characteristics. Instead, guidelines must be interpreted and adapted to fit the particular capabilities and context of individual programs.

This chapter summarizes issues involved in performing intake functions and then describes procedures for assessing the needs and resources of chemically dependent women. The first two subsections provide historical and background information. Readers who are primarily interested in procedural definitions and suggestions may wish to begin with the subsections on resources and processes. The chapter has the following six subsections:

1. Designing intake procedures;
2. Addressing women's special needs at treatment entry;
3. Providing appropriate environmental and staff resources for intake assessments;
4. Conducting the preliminary screening;
5. Completing the diagnostic assessment; and
6. Making treatment recommendations and referrals.

DESIGNING INTAKE PROCEDURES

Many general procedural issues must be resolved by each program as it examines and carries out its intake requirements. Six of these issues are discussed in the following paragraphs. These issues are interrelated, and program decisions in one area will affect those in several others. For example, a decision to restrict the amount of time allocated for intake will influence the scope and intensity of the assessment process. The nature and size of the client population, the types of treatment available, and the qualifications of the staff are factors that will also influence program decisions about intake procedures.

ISSUE 1: ESTABLISH PROCEDURES FOR INITIAL CONTACTS

Women are more likely to make indirect and tentative inquiries about treatment by telephone or through a secondary source than are their male counterparts. Each agency must be sensitive to likely approaches and then develop procedures that will accommodate female applicants and also fit their programmatic limitations. Issues to be considered are as follows:

- Will intake services be provided on a first-come, first-served basis; by scheduled appointments only; or by some combination of these procedures?

- If appointments are given, are they for specific hours, blocks of time (e.g., morning or afternoon), or specified days? Are there penalties for "no-shows"? How can emergencies be defined and handled flexibly and fairly within an appointment system (e.g., the woman who has just been evicted by a partner or husband, or the applicant who appears to be in withdrawal and threatens to commit a crime to obtain more drugs if not accommodated immediately)? And can an appointment system be operated without discrimination against those with language barriers or no telephones who tend to walk in for care?

- What, if any, priorities should be granted to applicants? How can these priorities be equitably determined (e.g., quotas from selected referral sources, walk-in volunteers, or persons under criminal justice system jurisdiction)?

- How can a program best respond to inquiries about treatment services from family and friends (e.g., provide direct pretreatment counseling for family intervention, send written information and guidance, refer to another crisis intervention or information and referral service)?

- What information should be given out and/or taken by telephone? Programs should have sufficient telephone resources to at least give detailed descriptive information and instructions on the intake process and duration, available treatment methods, eligibility requirements, and directions to the facility. Written materials on these topics should also be available.

- If telephone prescreening is attempted prior to an appointment, the program must decide how and whether to follow up if the appointment is not kept. Oral permission to recontact an applicant by telephone should be obtained but may be construed as a violation of confidentiality if the program conscientiously pursues these initial contacts. Individuals can be referred expeditiously to other appropriate resources (e.g., hospital emergency rooms, crisis centers), while interested candidates can be encouraged to come in during a specified time set aside for initial intakes. Records should be kept to determine the percentage of initial contacts that actually appear for services. Procedures can then be modified, as appropriate, to increase the number of initial telephone contacts who become applicants.

ISSUE 2: SET TIME LIMITS FOR INTAKE THAT MAKE TREATMENT ACCESSIBLE

Intake procedures should have a well-defined beginning during a client's first contact with a treatment program (or first appearance at the facility), a normal end when arrangements for treatment service delivery are completed, and a natural sequence of activities between these two events. Sometimes, however, applicants must deviate from established procedures when they need other emergency services or when personal crises interfere with normal routines. Because some types of treatment require more complicated examinations than others, the normal timeframes for diagnostic assessments will vary. For example, chemotherapy programs must validate both addiction status and drug abuse history before prescribing long-term drug therapy, whereas detoxification programs can initiate treatment for withdrawal immediately after current addiction is established.

In general, the outside limit recommended for the entire intake process is 3 days, but most programs should plan to start some services after the first day even if further tests have been scheduled or the results of others have not been reviewed. Rigid distinctions between intake diagnosis and service delivery can seriously impede treatment entry. Delays may stem from status definitions established by funding sources to qualify clients for reimbursement payments. Programs also hinder treatment access with extensive waiting periods, elaborate appointment procedures, inconvenient hours, undesirable locations, discrimination against readmissions, and lack of flexibility.

ISSUE 3: CONDUCT A COMPREHENSIVE ASSESSMENT OF THE WHOLE PERSON

One of the challenges of intake is to remain objective while assessing an applicant's treatment needs. Too frequently an individual program sees a woman only from the perspective of the services it can readily offer rather than discovering what really needs to be done. All major areas of the prospective client's life must be investigated, not just her drug-taking behavior, and immediate personal and physical crises must be alleviated if treatment is to be successful. An extended network of coordinated services from potential service providers is necessary to address the multiple problems of many drug-abusing women.

ISSUE 4: MAINTAIN A BALANCE BETWEEN THE SCOPE OF THE INTAKE INTERVIEW AND THE INTENSITY OF THE EXAMINATION

The requirement to be comprehensive in an intake assessment does not mean that every detail of an applicant's functioning must be scrutinized at once. The time restrictions of the intake process and the prospective client's shortened attention span while under the influence of drugs also put limits on the intensity of probing questions. Essential information can be gathered through structured interviews that give the potential client a chance to discuss major concerns. Intake workers should not move too quickly to encourage intimate revelations that are unnecessary for a preliminary treatment plan. The intake goal is to discover and rank the primary problem areas that have a potential for rapid intervention.

ISSUE 5: ESTABLISH TRUST AND OBTAIN ACCURATE INFORMATION, BUT DO NOT CREATE A THERAPEUTIC ALLIANCE AT INTAKE

The diagnostic interview at intake is the first opportunity for the prospective client to reveal important information and to invest in the treatment process. In many programs, a specialized intake worker screens the eligible applicants and conducts the initial interview(s). The intake process must be carefully constructed to create a climate of trust and nonjudgmental acceptance without developing a close worker-client relationship. Questions should be structured to stimulate self-examination that will be useful preparation for later counseling sessions, but the interviewer should not break down defense systems that the applicant has developed for coping. The consistency of the client's answers can be explored by asking for clarification, not by questioning reasons for behavior.

ISSUE 6: PROTECT CLIENT CONFIDENTIALITY WHILE OPENING COMMUNICATIONS AMONG TREATMENT PROVIDERS AND FAMILY MEMBERS

Programs that rely exclusively on self-reported information from the applicant and do not solicit different perspectives or confirmations from other provider agencies, employers, or family members may miss important insights and inadvertently encourage a limited and possibly inaccurate understanding of the prospective client. Confidentiality regulations do restrict free exchange of information with significant persons in the applicant's life, but they are not meant to inhibit approved communications, once consent for release of information has been obtained. Permission to involve appropriate persons in the diagnostic process or to obtain records should be sought as soon as possible to avoid one-sided client evaluations. Applicants who refuse such permission should not be denied admission but rather encouraged to cooperate at a later date with the program's policies. Many applicants may wish to avoid, or at least postpone, the negative impressions they expect will come from family members and associates. Their desire to be given a fresh start and to be evaluated on current activities should be respected, but with the understanding that treatment must eventually entail connections beyond the program staff.

In summary, applicants for treatment services should be encouraged by intake procedures that are comprehensive, cohesive, time limited, noninvasive, confidential, available, and supportive of a therapeutic alliance between the primary counselor and the client.

ADDRESSING WOMEN'S SPECIAL NEEDS

In the past several years, research studies on women entering substance abuse treatment programs have provided insights into the special problems and characteristics that distinguish them from both male drug abusers and nondependent women. These findings are reported extensively in other chapters of this book. This section reviews briefly some implications of these studies for the intake assessment process, particularly in the areas of physical-medical complications; psychological difficulties; family situations and living arrangements; social, economic, and legal needs; and drug abuse patterns.

PHYSICAL-MEDICAL COMPLICATIONS

Women drug abusers experience significantly more physical illnesses than do male addicts and are more likely than men to cite health problems as the reason for entering treatment. Chapters 6 and 7, this volume, highlight the most frequently encountered problems of this nature. These findings have several important implications for the intake assessment of women:

- Physical examinations for women entering treatment should be routine and comprehensive and include thorough dental, eye, and gynecological examinations.
- Where appropriate, needed services should be provided immediately through referrals to community resources. These referrals should be followed up and documented in the treatment case records.
- To the extent possible, physical examinations, especially for gynecological abnormalities and pregnancy, should be provided onsite at admission or through prearranged linkages with a nearby doctor or clinic. Andersen (1979) found that referrals and deferred examinations scheduled offsite are seldom completed or documented in the case records.
- The correlation between life changes or stress and physical illness needs to be assessed to offset change stresses and provide protection against physical problems precipitated by treatment, especially in outpatient settings (Andersen 1977). In women with lowered tolerance and high stress factors, residential referrals may be required to avoid health problems.
- Lifestyle and drug patterns commonly correlated with health problems should also be assessed at admission. These include the following:
    1. The dangers of medications in early pregnancy (Finnegan 1979);
    2. The potentially hazardous interactions of drugs and medications such as methadone, barbiturates, diazepam, and ethanol (Kreek 1980);
    3. The association of prostitution with venereal disease and vaginal and urinary infections;
    4. The potential of alcohol for liver damage;
    5. The association of parenteral drug use with hepatitis, thyroid abnormalities, bacterio-endocarditis, and renal disease;

6. The correlation of malnutrition with tuberculosis and alcohol abuse;

7. The need for birth control protection in treated women who have been experiencing infertility and menstrual irregularity while abusing narcotics and other polydrugs; and

8. The potential for false positive readings on syphilis serologies.

PSYCHOLOGICAL DIFFICULTIES

Many psychological factors can affect the intake and referral process. At treatment admission, women generally have lower self-esteem, greater depression, and higher anxiety than male addicts or other comparable but nondependent women (Colten 1979). Psychological problems make treatment entry particularly tenuous and are frequently expressed through helplessness, suppressed energy levels/immobilization, excessive self-criticism, or avoidance of stressful situations (Reed and Moise 1979b). Program personnel should keep in mind the following:

- Women who are pessimistic about themselves and their coping abilities need to be supported and accepted at intake rather than confronted with their problems.
- At intake, immediate practical assistance with real problems is more important than tests of motivation for treatment.
- Interventions or questions should not be too intensive or emotionally provocative early in the intake process.
- Intake workers should be prepared for negative and compulsive behavior and react with supportive and positive actions.
- Women who have experienced recent losses, appear excessively depressed and hopeless, or use selected drugs (heroin and nonopiates) should receive immediate evaluation and appropriate supportive services at intake.
- The sexual orientation and preferences of women should be sensitively and carefully evaluated at intake.
- Intake workers should be prepared to assess dangerous and stressful events in the lives of women clients, such as recent physical or sexual abuse.

FAMILY SITUATIONS AND LIVING ARRANGEMENTS

In assessing a woman's psychological status at intake, it is important to assess her current living situation, her family background, and her values about sexual roles and responsibilities. Stressful living conditions, role confusion and resentment, and familial patterns of addiction or deviance have important implications for initial intake assessments; consider the following:

- Women living alone with children or responsible for their care may need childcare assistance before treatment entry is possible. They also will need supportive emotional and physical relief from childcare responsibilities.

- Past or current deviant behavior among family members should be carefully assessed to understand its impact and influence on the woman's drug abuse patterns.

- Knowledge of the applicant's support system and values is necessary for treatment planning. Involvement of significant family members should be considered.

- When onset of drug abuse in women occurs concurrently with other deviant and rebellious adolescent behaviors, family deprivation may be less associated than immaturity. Supportive relationships, particularly with mothers, may be an asset in planning for treatment.

- Exploration of sex roles and options is important to the treatment process. Care must be exercised to avoid staff alinement on feminist, traditionalist, or other philosophies and attitudes. Such alinement may be offensive to applicants who are discovering and clarifying their own values.

SOCIAL, ECONOMIC, AND LEGAL NEEDS

The physical, psychological, and interpersonal-familial problems of addicted women are often exacerbated by social, economic, and legal needs. Not only are chemically dependent women likely to experience stressful family situations, but they may also have few friendships or support systems, limited employment skills, and few economic resources. The intake counselor must therefore evaluate the following:

- Childcare, legal entanglements, housing, or financial needs that threaten continuation in treatment.

- Vocational and educational rehabilitation needs.

- Past experiences causing mistrust and estrangement from others and leaving the applicant isolated, lonely, and incapable of reaching out for external social and emotional supports.

- Mechanisms used for coping with stress and abilities to share feelings in the counseling framework (to make appropriate referrals for therapy).

- Attitudes and motivation for participation in group support networks and whether those should be same-sex or mixed groups (some research indicates that most women share feelings more readily and participate more openly in same-sex rather than mixed groups [Aries 1976]).

- Relative perceptions of and trustfulness toward males and females (to make primary counselor recommendations).

- The potentially destructive impact of addiction on minor children through careful attention to neglectful or abusive situations that require intervention (e.g., helping parents protect children from their own angry impulses or from hazards in the environment).

DRUG ABUSE PATTERNS

As pointed out in chapter 2, chemically dependent women have distinctive patterns of drug abuse that differentiate them from addicted males. Therefore, treatment programs should carefully assess drug use and abuse patterns in female applicants:

- Determine potentially harmful combinations of drugs and identify behavioral correlates of particular drugs such as suicide attempts or criminal involvement.

- Assess situations associated with substance abuse and offer alternative coping mechanisms for self-medication to alleviate anxiety and pain or for hedonistic satisfaction and self-expression.

- Ascertain unanticipated negative consequences suffered after drug misuse and provide information related to areas of misinformation or ignorance, especially in women of childbearing age.

PROVIDING ENVIRONMENTAL AND STAFF RESOURCES

The initial impressions a woman forms at intake may be more decisive than the quality of services offered by the program. These first impressions may determine whether she completes the admission process and stays long enough to become therapeutically involved. This section discusses factors in facility design and location and staff qualifications and behaviors that are important in planning

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or rearranging a diagnostic process attractive to the chemically dependent woman.

Many types of facilities provide intake services for drug-abusing women. They range from outpatient clinics and residential units for women only, to freestanding coed facilities in both urban and rural areas (with a variety of single- or multiple-treatment modalities), to programs housed and operated by hospitals, courts, jails, community mental health centers, nonprofit organizations, and businesses and industries. Most smaller programs provide intake services in the same facility where treatment activities are conducted and select or rotate their staff to perform all functions, from evaluation and admission to counseling, aftercare, and followup.

Some agencies operate several clinics or facilities under one administrative organization and locate them in different sites across a city or region; they may provide a variety of separate treatment approaches, such as drug-free residential care, inpatient detoxification, and outpatient methadone maintenance. In these programs, all intake and referral may be conducted from a central facility. It may be possible to segregate and relocate these functions strategically to attract and serve more women. In smaller programs, creative and cooperative arrangements may be arranged for specialized physical and laboratory examinations (e.g., through joint purchase-of-service agreements with a group health practice or a women's medical clinic), with intake interview and orientation functions conducted in separate drug abuse treatment facilities. Most programs, however, manage intake functions independently. Given what has been learned about the special needs and differences of women, such programs should be reexamined in terms of site location and visibility; spatial design and arrangements; interior decorations; and staff qualifications, development, and deportment.

SITE LOCATION AND VISIBILITY

The physical location of the intake facility should not pose barriers for women needing services. The neighborhood surrounding the intake site should be one that is familiar and acceptable to the target group of women served. For example, if a mixed group of middle- and lower-class women are served together, the selection of a neutral business section of the downtown area may be preferable to a suburban shopping mall or a public housing development. The heart of skid row, gambling and pool hall districts, and sections full of male bars and adult bookstores are not appropriate places for intake services for women.

It is unrealistic to expect operating programs to invest in new facilities or even to find ideal facilities. But all programs should take certain steps to assess the site location and facilities and improve the situation for women clients. Women traveling alone or with small children need protection from both physical danger and sexual harassment on route. Program staff can periodically check the street lighting along the nearby access routes and look for the places that loiterers frequent. Requests for better lighting or more security can then be made to the community as necessary. Special planning may be needed if intake facilities are located more than one block from bus or subway routes or parking spaces. Women should not have to detour through back alleys or dangerous areas or go down dark hallways to reach services. Barrier-free access should be maintained for the disabled. Handrails on all steps, adequate lighting, clearly marked exits, smoke detectors, and emergency care equipment are examples of required minimal safety features.

Ideally, public transportation to the intake service facility should be readily available, well publicized, and affordable by the anticipated applicants; otherwise, the program may have to arrange for transportation to attract women into treatment. Many chemically dependent women do not drive or do not have access to private cars. They frequently depend on friends, partners, or public vehicles for travel. Staff members at the intake units should volunteer helpful information about bus routes, schedules, simple directions, parking spaces, and so on that can make access to the facility less burdensome.

The premises surrounding a treatment facility should be clean and free of environmental hazards. Garbage cans should be covered, bushes clipped and grass mowed, entrance halls cleaned, and broken glass repaired. During the summer, unemployed male clients often congregate at program facilities, presenting a barrier for women seeking treatment. Programs should make every effort to prevent these situations.

The program should also consider the directional signs and nameplates marking the entrance to a program. Because women often feel stigmatized by their drug dependency problems, they may be embarrassed to ask directions or to enter a publicly advertised drug treatment program. Confidentiality is possible if the program's name camouflages the facility's purpose and if directional signs are posted. To the extent possible, the address should be self-explanatory, giving the room or suite, building name, or whatever is required. The name of the program itself may emphasize services for women and stress the expectation for recovery rather than drug dependency. Thus, "The Women's Center," "Phoenix House," or "New Choices" are preferable to "Addiction Services" or "Drug Abuse Therapy Center." Clever logos and symbolic acronyms are other ways to create a good public image (National Center for Alcohol Education 1979).

SPATIAL DESIGN AND ARRANGEMENTS

Within the facility, spatial design modifications can make intake services more efficient and appealing to women. Many drug treatment programs apparently are not familiar with environmental planning and architectural programing, a profession that combines interior decoration and architectural planning with functional design suitable for programmatic activities. The following introductory readings on the subject present concepts of design and renovation suitable for health care environments.

- Bureau of Community Health Services and Office of Facility Engineering and Property Management. The Health Maintenance Organization Facility Development Handbook. Washington, D.C.: Department of Health, Education, and Welfare. July 1974.
- Sanoff, H. Methods of Architectural Programming. Stroudsburg, Pa.: Dowden, Hutchison, and Ross, 1977.
- Lifchez, R.; Whitman, F. D.; Crowell, C. Environmental Design for Social Model Alcoholism Programs. Berkeley, Calif.: Department of Agriculture, College of Environmental Design, University of California, 1976.
- Gutman, R., ed. People and Buildings. New York: Basic Books, 1972.

Consultation on spatial design is also available to programs serving economically disadvantaged populations through community design centers, such as those established jointly by the American Institute of Architects (AIA) and Volunteers in Service to America (VISTA). Locations of these free services may be found by calling VISTA/ACTION at (800) 424-8580, extension 82.

The efficient arrangement of space and the deployment of staff within the intake program unit can improve the orderly and personalized processing of prospective clients. A receptionist should be immediately visible upon entrance to the unit and always available as a facilitator of the intake procedures. A desk can be strategically located for monitoring the waiting area and limiting access to diagnostic counselors or other examiners. The receptionist should also protect the confidentiality of client logs and intake forms from inspection by visitors.

The adjacent waiting area must have adequate space for applicants and family members, including children, who may accompany them. Extra chairs should be available. Other suggestions for furnishings and equipment for this area are made later.

An intake unit, at minimum, must have private rooms or spaces for interviews and examinations that should be large enough to accommodate groups. A desk or table for writing is essential but should not dominate the room or separate the applicant from her interviewer.

Bathroom facilities are more important in drug treatment programs and intake services than in many other health care programs because of the need for urine surveillance. Observation windows in the doors or walls of the bathroom allow staff to monitor urine sample collection without being physically present in the toilet area.

Because women are usually provided with stalls, even in public toilets, they are not used to urinating in front of others and also find it difficult to direct urine into a small-mouthed bottle. To avoid surprise and offense, program staff should provide a clear and reasonable explanation for the surveillance requirement before a specimen is collected and be as discrete as possible during the procedure. In programs where physical examinations are conducted onsite, women need adequate dressing rooms and locked storage space in which to leave clothing and personal possessions.

INTERIOR DECORATION

Most women entering treatment seek a sense of safety, protection, calm, and acceptance, all of which can be reflected in the physical decor. Order and security are reinforced through simplicity and solidity in the furnishings. The dreary, depressing, and dirty surroundings of many drug treatment programs can be changed drastically with fresh paint and a few well-chosen pieces of furniture and pictures. Wall and floor coverings, for example, are generally most appealing to women if they are subdued and muted without being institutional. Plain, soft variations of warm earth tones are the most suitable colors. Bright hues and bold, busy patterns can be tiresome and overpowering to women who are under stress or physically ill at intake. Small touches like plants, decorative tissue boxes, and a clock add welcoming notes.

Similarly, rugs, draperies, wall hangings, or acoustical ceilings provide sound barriers and a good backdrop for quiet conversations. Continuous music can be soothing, too, but reaching agreement on a radio station may present too many difficulties to make this effort worthwhile.

Lighting also contributes to the atmosphere of a facility. A few well-placed lamps in the waiting area and on desks can make the room more inviting. Windows provide welcome daylight but can be a distraction if sunshine blinds the applicant during an interview or if outside noises disrupt the diagnostic process. Easily managed shades or curtains should be provided.

The furniture should represent a reasonable compromise between comfort and practicality. Upholstery should be durable and washable. Pieces should be small enough to be rearranged easily, especially in the waiting area, where chairs should be grouped in small clusters to encourage conversation and free circulation. Low tables should be durable and large enough to hold reading materials, clip boards for completing forms, and cups and snacks. Also provide wastepaper baskets and a rack or closet for coats and umbrellas. If smoking is not permitted, a small sign should announce the fact and the receptionist should quietly enforce the decision. The room should convey a feeling of privacy and relaxation.

Pictures, posters, and other artwork can express the program's intentions and philosophy. The choice of subject matter is important:

Not everything has to depict anti-drug-abuse or feminist themes. Many women appreciate exhibits of local artists or craftspersons and ethnically relevant works. Be subtle and don't overload already overstimulated and exhausted applicants. Be careful to insure anything of value and to install pieces securely to avoid theft. Women may especially enjoy quality photographs with universal themes involving children, male partners, female friends, and family members in scenes of joy, pathos, tenderness, and loneliness. But remember that too much sentimentality can be cloying, just as pornographic artwork or calendars showing women as sexual objects are offensive. In addition to pictures, a waiting area can be equipped with educational materials, brochures, and current magazines of interest. If staff members lack the time, a volunteer could help keep this room supplied. An attractive bulletin board can hold clippings about services for women, community happenings, new information on drug fads, or facts about health issues. A looseleaf notebook or catalog of available treatment services in the community, describing services, requirements, and hours, can be developed to introduce women to potential referral resources. Although many applicants may not be in the mood to use these materials on the first visit, their availability may encourage a later interest.

OTHER AMENITIES

Several other special features can enhance the appeal of an intake facility, especially the provision of space, equipment, and supervision for small children. A childproofed play space and a basketful of safe plastic or rubber toys that are washable or disposable can entertain infants. A few books, crayons, games, or office supplies, when supplemented by adult imagination, can keep young children entertained for hours. A blackboard hung low on a wall could double for staff training and a game of tic-tac-toe. The most essential ingredient for babysitting at intake is the commitment to provide the service as necessary and to dedicate staff time.

If the full intake process takes several hours, light refreshments should be available. Information on the location of snack bars, vending machines, or cafeterias should be available. Directions to a water fountain are also helpful. Some facilities have sufficient resources to offer herbal teas, fruit juices, or decaffinated coffee. One intake unit was given complimentary coupons for hamburgers by a fast food chain to distribute to needy applicants or those experiencing unanticipated delays in processing. Appeals to beverage manufacturers or distributors might produce refreshments as part of their advertising.

Other courtesies appreciated by women are the offer of a telephone to arrange for transportation after intake is completed; the provision of written instructions for a referral; a room with a couch for the woman to take a nap if she is not feeling well; and handouts of prepackaged brochures on health care, job programs, childcare, displaced homemaker services, emergency telephone numbers for assistance with various crises, and other pertinent tips.

STAFF QUALIFICATIONS AND DEVELOPMENT

The staff members who provide diagnostic intake services make even more of an impression on prospective clients than the facility's surroundings. Their selection, training, and behavior are crucial to effective operations. Their communication skills and the cooperative relations they establish with women during intake determine, to a large extent, the accuracy of the information collected, the perceptiveness of the diagnosis, and the mutuality of the treatment planning and placement process.

No one staffing pattern is appropriate for the intake component of treatment programs. The number and functions of intake workers are determined by the size and orientation of the program's treatment services. Large-scale methadone clinics or inpatient detoxification units will probably have the necessary medical or nursing personnel to conduct physical examinations and administer health questionnaires onsite. This situation is less likely in smaller residential programs or in drug-free treatment, where arrangements and appointments for medical exams must be made outside the facility and at a later point in the intake process.

Many smaller programs assign one staff person to conduct all intake interviews along with other counseling duties. Other programs rotate staff through the intake component as a temporary assignment. These different staffing models have various advantages and disadvantages. Rotating staff members are less likely to "burn out" on their intake duties and provide more flexible and varied backup capabilities if intake demands increase unexpectedly or if another worker is on leave. Permanent workers, in contrast, can demonstrate more expertise as diagnosticians after they refine their skills through intensive practice. They may be more careful and consistent, too, about records and referral followup on applicants than short-term rotating workers would be.

Exhibit I suggests five functional areas that must be covered by each intake component, whether staffed by one or two persons or by 25 specialists. These basic functions, which may be conducted either directly by paid staff or indirectly under contracts, are

- Administration,
- Diagnosis and review,
- Referral coordination,
- Reception and recordkeeping, and
- Medical and psychological testing and examination.

The duties allocated to each function may be combined in a variety of ways and assigned as task responsibilities to different positions. For example, the diagnostic counselor position in one program may incorporate tasks from a referral coordinator's job

EXHIBIT I. Functional categories and tasks for staff positions in intake components

Functional Category: ADMINISTRATION

Selected Tasks:

- --Develops and implements policies that encourage chemically dependent women to complete intake and enter treatment.
- --Designs specific procedures to carry out these policies and assigns responsibilities to other staff members as necessary.
- --Recruits, trains, and supervises staff who are responsive to women.
- --Establishes and accounts for budget necessary to implement policies.
- --Reviews facility accommodations for women and arranges for necessary renovations, cleaning, supplies, etc.
- --Insures protection of client and applicant confidentiality and privacy in records, information releases, research requests, etc.
- --Compiles data to evaluate and improve intake services for women.
- --Advocates new services that meet women's special needs and are not available in the community.
- --Establishes Task Group on Services for Women to review and develop policies and to make recommendations regarding change.

Functional Category: DIAGNOSIS AND REVIEW

Selected Tasks:

- --Conducts preliminary assessments of women to determine and resolve immediate barriers to the intake process or treatment entrance (e.g., medical emergencies, financial arrangements, childcare, interpersonal crises).
- --Conducts in-depth interviews to determine the substance abuse patterns and sociodemographic, psychological, legal, educational employment, interpersonal, and community services status of applicants.

--Administers medical-psychiatric history interviews, focusing primarily on health problems, to applicants.

--Establishes necessary rapport with prospective clients to elicit accurate information and develops sufficient trust to probe for personal experiences and feelings.

--Observes behaviors of applicants to corroborate interview findings.

--Documents observations and interview findings on standardized forms.

--Identifies significant health complaints and drug-medication problems needing the special attention of the examining physician.

--Arranges appointments for other diagnostic tests and examinations that are conducted offsite as part of the intake process (e.g., physical exam and psychological and laboratory tests) and coordinates findings from other examiners regarding further treatment needs and service recommendations.

--Explains treatment options, procedures, and different modalities or approaches to applicants and other family members, as indicated.

--Presents recommendations to applicant and designated others, as appropriate, and negotiates mutually acceptable treatment placement.

--Introduces applicant to her primary counselor, who receives all intake records and assumes responsibility for other community referrals.

--Forwards any new information to the primary counselor, as received from the laboratory, former treatment agencies, etc.

Functional Category: REFERRAL COORDINATION

Selected Tasks:

--Establishes liaison with relevant community agencies for medical and dental treatment, emergency care, and other social, financial, legal, or psychological services needed by women drug abusers in the intake process.

EXHIBIT I. Continued

--Advocates new or improved services not currently available in the community.

--Makes regular calls to primary treatment and referral resources to determine any changes in eligibility requirements, hours of operation, etc., and communicates these to the intake workers.

--Coordinates and consults with other treatment programs or community agencies on the special health and social service needs of chemically dependent women and reviews and recommends these resources to intake workers to meet treatment planning needs.

--Makes regular followup calls, under the guidance of the intake workers, to discover whether applicants have kept scheduled appointments and referrals.

--Coordinates with outreach services that identify chemically dependent women and negotiates screening and referral arrangements.

Functional Category: RECEPTION AND RECORDKEEPING

Selected Tasks:

--Answers telephone inquiries from, schedules appointments for, and greets women applicants for intake services.

--Guides flow of applicants through the intake process, notifying other staff of delays or persons with special needs.

--Provides informational packets or specified forms to all applicants, as required.

--Records routine information such as applicant's identification, insurance benefits, etc., and helps applicants complete standard forms.

--Supervises and attends children, as necessary, and provides other courtesies such as refreshments, directions.

--Files, retrieves, and forwards applicants' records according to established procedures that fall within confidentiality regulations.

--Compiles and tabulates statistical data from the files, as directed.

EXHIBIT I. Continued

- --Records financial information, prepares and submits bills, and keeps accounts.

- --Checks and reorders supplies and records receipts.

Functional Category: MEDICAL AND PSYCHOLOGICAL TESTING AND EXAMINATION

Selected Tasks of the Nurse/Medical Technologist:

- --Reviews health status forms with the applicant and probes any significant information on problems and complaints.

- --Assists with medical/gynecological examinations and takes vital signs.

- --Observes and records physical signs and symptoms of the applicant to confirm self-reports and laboratory findings.

- --Provides counseling on health care to women identified during the examination as having problems needing immediate attention (e.g., pregnancy, lack of birth control information or equipment, venereal disease, infection, dental pain, etc.).

- --Collects samples of blood and/or urine for laboratory testing and prepares specimens for submission to appropriate labs.

- --Reviews and records all test results from the labs and notifies the physician and/or the intake worker of abnormal findings requiring followup.

Selected Tasks of the Doctor or Physician Assistant:

- --Conducts complete physical examinations, including gynecological investigation, PAP smear, and swab for detection of gonorrhea.

- --Reviews medical history and laboratory findings for indications of abnormalities.

- --Recommends further testing, as necessary, for confirmation of suspected health problems.

- --Confers with intake staff, as necessary, to resolve any conflicts among findings.

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EXHIBIT I. Continued

- --Prioritizes health care needs and recommends referrals and timeframes for appointments.
- --Trains staff in emergency procedures for overdoses, seizures, etc., and arranges procedures for hospital transfers in emergencies.

Selected Tasks of the Psychologist/Psychiatrist:

- --Confers with intake workers regarding applicants who appear to have severe psychological problems and recommends and arranges referrals for emergency care or further evaluation.
- --Conducts mental status exams, psychological tests, or psychiatric examinations, as appropriate.
- --Conveys findings and treatment/referral recommendations to the intake worker and/or the treatment staff.
- --Serves as counselor to the intake staff on problems and frustrations related to working conditions and makes recommendations to alleviate such problems.

description at another program or the telephone screening and welcoming duties from the receptionist's position at still another agency.

A basic staffing pattern for an intake component, at even the smallest treatment program, will probably include at least three positions with duties that reflect intake services. The program administrator/manager may delegate intake administrative tasks to the diagnostic counselor but retain overall responsibility for policies and procedures approvals, budget, staffing, facility management, and community liaison. Similarly, the secretary/receptionist/records clerk may have primary duties related to the total program but also have assignments that support the intake functions. Moreover, even though an intake specialist/diagnostic counselor carries the basic responsibility for screening, assessing, and placing new applicants, the backup of other counselors or social workers on staff and medical/psychiatric personnel under contract should be available to help identify special referral resources, to match these with client needs, and to coordinate appropriate linkages.

The qualifications recommended for each intake position will vary according to the duties assigned, the current staffing patterns and qualifications available in the program as a whole, and the salary scales or employment situation in the area. Obviously, a program with only a few treatment staff positions, which are currently filled by state-certified counselors without college degrees, will not be likely to hire a professional social worker as the intake specialist. In contrast, intake workers with advanced degrees and several years of qualifying experience may be preferred at another program but be financially impracticable in the total staffing plan. In general, the primary diagnostician for an intake component should have at least 2 years of qualifying experience under supervision in a clinical setting, preferably in a substance abuse treatment agency, and have a college degree in the humanities or social sciences. An advanced degree in guidance or rehabilitative counseling, social work, or clinical psychology may be substituted for experience. Likewise, extensive clinical experience and training can be substituted for educational experience. Experience is generally preferred in therapeutic communities because of the knowledge, skill, and attitudes developed. Programs reevaluating their intake services would be wise to place a member of the senior professional staff who has the best skills as the head of the intake component, no matter how the other duties are assigned or rotated.

The match of staff members' personal characteristics with those of the population in treatment is another concern when hiring or redeploying personnel. The issue of women on staff and as intake workers can be approached from several perspectives. Women applicants will form more positive impressions if at least some program staff are women working in positions other than secretary or clerk. Programs serving only female clients may elect to have only women on staff. In developing intake components, however, most programs will consider a mixture of demographic factors, including sex, that reflect the characteristics of the target population. Some balance is generally needed to represent different age groups, races, ethnic backgrounds, sexual preferences, drug or alcohol abuse experience, and professional orientation. Sex is only one factor in the match of skills and experiences with functional requirements and client preferences.

Established programs will probably not hire new staff for intake as they review their efforts to attract women, but they can retrain current personnel and consider replacements as opportunities arise. The sensitivities of current workers to the characteristics and needs of chemically dependent women can be heightened by good staff training. This may be accomplished through seminars, workshops, or staff meetings. Some suggested topics include the following:

- Research findings on characteristics of chemically dependent women;
- Appropriate community resources for women;
- Changing family roles and responsibilities of women and the reactions of males;
- Alternative career opportunities for women;
- Sexual assault, harassment, and incest;

- Feminist support groups;
- New concepts of sexuality;
- Domestic violence;
- Antipornography campaigns;
- Day care concepts;
- Management of pregnancy in addicted women;
- Patterns of alcohol, cigarette, and drug consumption among women; and
- Staff attitudes toward women clients.

STAFF BEHAVIOR

A complete list of dos and don'ts for intake workers to guarantee that their actions and attitudes will be unobjectionable to all women is, of course, impossible. What offends one woman may not bother another. But frank examination of current practices and open discussions during staff training sessions may be needed to raise the consciousness of staff members about how certain actions can affect selected female subgroups during intake. Unintentional slights to racial, ethnic, age, or handicapped groups are legion. Rapid exploration of marital problems or sexual values with a Puerto Rican woman, for example, may be an unacceptable breach of manners, as is constant direct eye contact with a Native American. Resolution of such issues as how to greet, touch, smile at, laugh with, or show empathy for different types of women can be a valuable step toward improving intake services.

Some male staff members will need to guard against chauvinism and stereotyping. They should not expect women to be more patient than men in waiting for services or to be "crazier," sicker, more emotionally volatile, dependent, or manipulative than their male counterparts.

Other potentially offensive behaviors by staff members are choice of language, form of address, and clothing style. Although few women today express shock at foul language, too much "street talk" is both unprofessional and unnecessary during an intake interview. Applicants may be asked what form of address they prefer; "Mary" may be too informal for an old-fashioned grandmother and "Ms. Jones" even more offensive. Similarly, overly stylish or expensive clothing worn by counselors may be perceived as intimidating by women of lower economic status. Other styles will be criticized as too "hippy" or shabby and interpreted as unprofessional and demeaning.

Because most women who come to intake are depressed, easily discouraged, and pessimistic about their self-worth (Colten 1979; Reed and Moise 1979b), they are frequently difficult to engage in therapeutic dialog. Gentle probing may be necessary to elicit responses from these women. Their low self-esteem tolerates little criticism, and intake staff will have to reach out to extricate women from their isolation and play up their strengths and skills.

Although some women will be very compliant and nonassertive during intake, others may throw up barriers of resistance, including acting out frustrations and hostilities to prove their unworthiness. Such provocative actions must be countered with positive suggestions and assurances rather than confrontational reactions in order to break the vicious cycle of poor performance and rejection.

Women with high anxiety levels need extra attention: Tension and anxiety interfere with concentration. Explanations and instructions should be given quietly and clearly and repeated as often as necessary. Written materials that are simple and direct can support important information. Forms should not be a substitute for personalized discussions, however, and should never be distributed with a curt, "Here, read this and ask questions, if you have any."

Finally, depressed people are depressing, and intake workers who interview women will need help with their own feelings if "burn out" is to be avoided. Listening to troubles and probing for problems without a chance to see improvement in treatment can be discouraging to intake workers. Readmitting the same clients over and over again adds to these frustrations. A good intake interviewer can be given relief in several ways: by providing therapeutic help to the staff as a group; by rotating to a treatment unit periodically; and by receiving adequate time off. One form of daily relief is humor; intake workers naturally seek diversion from a sometimes oppressive routine by joking with each other. This is a valuable tension reduction response if indulged in while away from the applicants' hearing in a staff lounge during breaks. A separate space for relaxation in an intake unit also allows workers to eat or conduct personal business away from clients.

CONDUCTING THE PRELIMINARY SCREENING

The diagnostic assessment and intake process is the initial step in treatment, and its activities can be divided into three substeps: preliminary assessment, diagnostic evaluation, and treatment recommendations and referral. This section addresses the first steps that staff members must take when a woman begins the intake process--how to greet her, how to make her comfortable, what questions to ask, and who should interview her. This procedure is called the preliminary assessment or screening and has three parts:

- Explanation of the intake process to the applicant, including its purposes, confidentiality safeguards, time requirements, and voluntary consent requirements.

- Determination of the major motivation for treatment and identification of emergency situations or other barriers to the continuation of the diagnostic assessment that will require immediate diversion from the intake process.

- Verification of applicant eligibility for treatment and continued intake processing or referral to a more appropriate resource.

These three parts are interrelated and do not necessarily follow this order, although they are depicted as following one another in figure 1. The guidelines presented in this section suggest approaches tailored to the needs and problems of women.

EXPLANATION OF THE INTAKE PROCESS

Intake begins with the first contact the applicant has with the treatment program: by telephone, through a referring agency, or by walking in. The receptionist or intake worker must answer basic questions about the services provided and describe the intake process. A short brochure or written instructions can be helpful Such a tool may be sent to telephone inquirers or presented at the first appointment. A written description will be useful for later reference to provide the client with a more detailed explanation of the purposes and results of each procedure. A woman with high anxiety about entering treatment may not understand long oral explanations but will feel reassured by a written reminder of any directions she must follow and a simple description of what she can expect. Important educational information can also be imparted through this medium, explaining, for example, the need for an alcohol history if liver damage is suspected or the importance of birth control practices for stabilized methadone clients.

Intake workers can use the brochure or an oral dialog to explain (1) how long the intake process will take, (2) what is involved and why, (3) how a treatment referral will be made, (4) what safeguards are taken to protect confidentiality, (5) what consent forms must be signed, and (6) what eligibility tests must be met before the intake process can continue.

After this explanation, the inquirer should be asked whether or not she wishes to apply for services and to continue the intake process. Some telephone callers may not be ready to make an appointment or may need help not offered by the treatment program. Referral to a more appropriate resource should be offered.

The applicants who visit the program may not have made adequate arrangements to continue intake on the same day. A young mother, for example, may have to hurry home to greet schoolchildren. Other applicants may have arrived too "high" to complete intake and will need to reschedule an appointment. This is always a difficult situation for program workers, however, because a woman's decision to enter treatment may be tenuous, and women who do not complete intake on the first day often either fail to return or return only when they are in another crisis. The staff must be persistent in

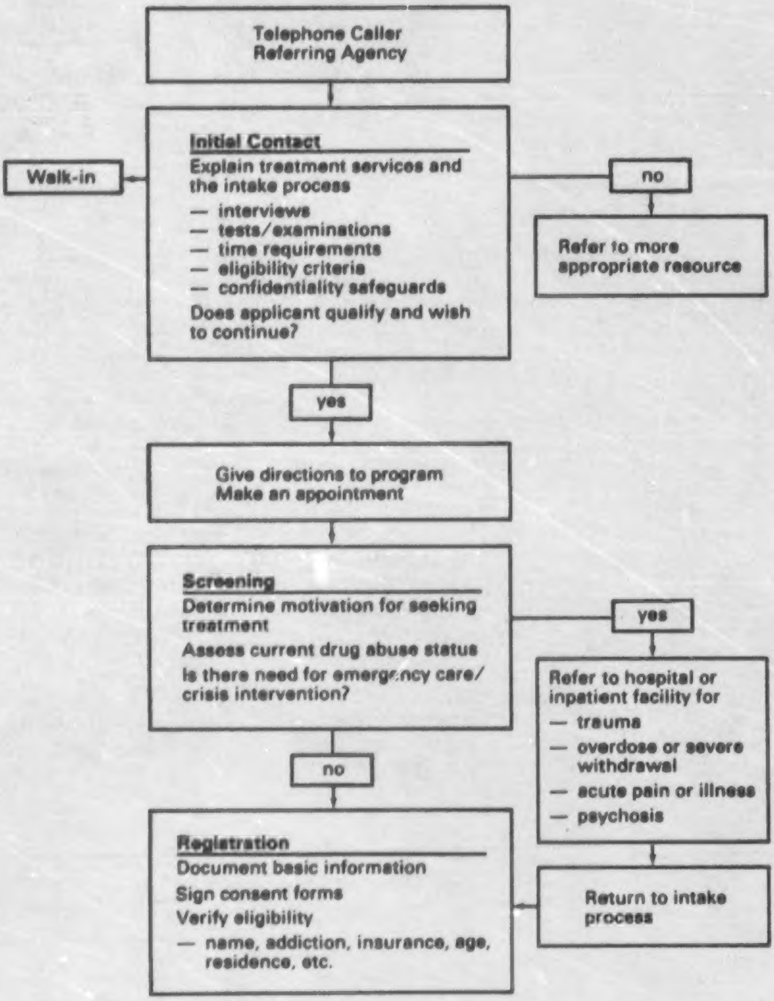
Telephone Caller
Referring Agency
Initial Contact
Explain treatment services and the intake process
— interviews
— tests/examinations
— time requirements
— eligibility criteria
— confidentiality safeguards
Does applicant qualify and wish to continue?
Walk-in
no
Refer to more appropriate resource
yes
Give directions to program
Make an appointment
Screening
Determine motivation for seeking treatment
Assess current drug abuse status
Is there need for emergency care/crisis intervention?
yes
Refer to hospital or inpatient facility for
— trauma
— overdose or severe withdrawal
— acute pain or illness
— psychosis
no
Registration
Document basic information
Sign consent forms
Verify eligibility
— name, addiction, insurance, age, residence, etc.
Return to intake process

FIGURE 1. The preliminary screening

order to complete intake on the same day or to followup with telephone contacts if a woman leaves early, promising to return. In such situations, staff should obtain basic permission to record the applicant's name, permanent address, telephone number, and convenient time for calling her to discuss the treatment services. The intake worker may also request the name of a friend or family member who will know where the applicant is and has written permission from the applicant to discuss her treatment needs.

DETERMINING TREATMENT MOTIVATION AND POTENTIAL BARRIERS

The preliminary assessment of applicants takes only a few minutes but should be conducted in privacy by an assigned staff member, not in the waiting area by a distracted clerk. It is important to take time for introductions and a few pleasantries that will establish the interviewer's interest and concern. The intake counselor should carefully observe the woman's responses and note how she answers questions: whether she is relaxed, in pain, hostile, unduly agitated, or excited. Body language as well as verbal contact is important. The first questions should be casual and can include how she got to the center, who accompanied her, or how she is feeling. The purpose is a brief social exchange to put both persons at ease.

The assessment begins with questions about the reasons the woman came to this intake unit or this program at this time. Motivation to seek help for a drug abuse problem is almost always related to an immediate crisis: Something has happened to make this day or week different from others. The applicant may have contemplated treatment for some time, but the moment of decision usually hinges on some pressure, large or small. The reason may be as simple as a ride offered by a friend who is in the program or as traumatic as the death of a mate from an overdose, a threat from protective services to remove an abused or neglected child, a violent fight with a pimp, pusher, or lover who is the drug supply source, or physical pain from an abscess at the injection site.

Treatment entrance for the chemically dependent woman is often precipitated by somewhat different crises than those experienced by men. Some of these differences have already been mentioned in the earlier comparison of admissions characteristics. Two differences are worth repeating:

- Women are much more likely than men to cite health problems as the motivation for seeking treatment (Andersen 1979; Tucker 1979). Addicted men, in contrast, perceive their drug problems to be more severe than do women (Tucker 1979). This difference may reflect socially acceptable sexual stereotypes: Women are more likely to seek medical assistance for physical problems that may be stress-related, whereas men can retain a male mythology of strength if they describe a drug problem.

- Women entering treatment have experienced more stressful life situations in the month before treatment than other nonaddicted women or comparison men. The most frequently encountered problems in addition to health are finances, childrearing, family situations, and other personal and social relationships (Tucker 1979). Addicted women less frequently come to treatment because of pressures from the criminal justice system. These women are suffering from loneliness and isolation and desire more meaningful relationships, yet they have seldom sought assistance for interpersonal problems and may not easily enter into intimate discussions or know how to identify emotional dissatisfactions as stresses.

Determination of the motivation for treatment provides clues to the applicant's lifestyle, treatment expectations, the immediacy of any crises, and other persons who should be involved in the treatment process. For example, the courts, an employer, or another social agency may wish to be informed of treatment placement and progress. Family members may accompany the applicant to the facility and may also want to hear about treatment. Permission forms will be needed from the applicant before information is released to anyone for any purpose.

In addition, the applicant's current drug status also should be investigated during the preliminary assessment. This is necessary to determine her physiological addiction status and imminent or current withdrawal or overdose symptoms. The interviewer's observations will confirm or raise doubts about answers to the following questions:

- What is the general pattern and substance abuse history of the applicant?

- What drug(s) is she currently using, in what amounts (dosages) at what frequency levels, in what combinations, by what route(s) of administration, and how long has this pattern continued over the past 2 to 4 weeks?

- What drug(s) have been taken in the past 24 to 72 hours?

- How is the applicant feeling now?

An experienced counselor can evaluate, from this information, whether the woman can continue the interview and complete the intake process in relative comfort and with adequate attention and responsiveness. Many applicants will be mildly high at intake. Reassurances may be necessary that intake will be completed or that symptomatic relief will be available before withdrawal begins. Care should be taken, however, not to ignore or discount a woman's descriptions of her physical discomfort as mere exaggerations. Because women are culturally allowed to complain and express pain, some staff members, female as well as males, may assume that all symptoms are distorted. Laboratory testing and medical examination can help distinguish the severity of the situation more objectively. Support and empathy, however, should not be withdrawn even when exaggeration is displayed.

Although the intake assessment may be aborted at any point if major barriers are discovered, several emergency situations may become obvious in the early screening or when a woman arrives at the facility. The following symptoms or situations require immediate action and deviation from the routine assessment procedures. The assessment of some of these problems is explained more fully in a later section:

- Physical trauma or visible injury;
- Fever and severe specific or nonspecific pain;
- Symptoms of overdose from various drugs (e.g., coma, respiratory depression, nystagmus, convulsions, delerium, incoherence, extreme paranoia or emotional instability, hyperactivity, tachycardia, cardiac arrhythmias);
- Severe withdrawal symptoms, especially from barbiturates, alcohol, tranquilizers, or combinations of drugs (e.g., tremulousness, agitation, confusion, convulsions, abdominal cramps with diarrhea and vomiting, severe depression);
- Severe reactions to drugs, especially hallucinogens or phencyclidine (PCP), that mimic psychotic behavior;
- Suicidal threats or actions;
- Violent actions or threats;
- Visible jaundice; or
- Psychotic behavior manifested in hallucinations, paranoia, hysteria, manic states, disorientation, extreme anxiety and fear, or other dysfunction.

All of these situations require medical or psychiatric intervention, usually at an inpatient facility. Some intake units have the capability to further assess the problem onsite, where a physician can complete a rapid urine sample screen or physical examination, for example. Staff in other units without direct onsite medical assistance need clear criteria about who to refer, where, and with what symptoms. A physician's consultation should be sought for these standards.

Intake unit staff in all facilities should be well prepared to distinguish emergency situations and to take predetermined actions. Two steps are involved.

1. Training in emergency procedures to assist the applicant until a referral is made (which may be provided by the consulting physician); and

2. Formal agreements with preselected facilities to handle anticipated emergencies and up-to-date information on how to facilitate referrals (see chapter 5).

When a distressing emergency occurs at an intake facility, staff should know in advance how to handle it. They must do the following:

- Take the distressed woman to a predesignated private space that has a bed or couch and some emergency equipment (e.g., wrapped tongue suppressors for convulsions, a blood pressure cuff, first aid supplies, naloxone, ipecac, etc., depending on the training of staff and proximity to assistance). This isolation stops panic or hysteria among other clients and calms the victim and any family or friends who may be with her.

- Assign a counselor, nurse, or other staff member to stay with the applicant and reassure or assist her while the situation is assessed or help is summoned. This person should know how to respond to the woman's needs while remaining calm and efficient. This person should continue to collect important information about the applicant's name, address, telephone, next of kin, hospitalization insurance or payment potential, family situation, and development of the problem. This may be obtained from a person who accompanied the woman to intake, if necessary.

- Assign a second person to arrange for necessary help or assistance by calling an ambulance, the hospital, etc. This should be done in a separate room so that the situation can be evaluated more objectively and rationally; reports can be made periodically to the staff member who is with the applicant.

Cooperative arrangements between the intake unit and necessary facilities to handle emergencies should specify policies and practices at each facility so that precious time is not wasted when services are needed. The following types of facilities should be included:

- Hospital emergency rooms equipped and experienced in treating drug overdoses, especially from barbiturates and other sedatives, tranquilizers (benzodiazepines), narcotics, analgesics, combinations with alcohol, and severe reactions to hallucinogens such as LSD, PCP, the major tranquilizers, etc.

- Inpatient hospital or freestanding medically supervised detoxification facilities that will accept women withdrawing from barbiturates, alcohol, tranquilizers, amphetamines, narcotics (with complications), and combinations of these drugs. (Only severe cases in which the applicant is too sick to continue intake should be referred at this point before an assessment is completed; otherwise, postdetoxification treatment may be delayed.)

- Hospital clinics or medical services that treat hepatitis and other liver disease and disorders, renal dysfunctions, heart problems, dermatologic infections, and other bacterial infections.

- Psychiatric hospitals or residential mental health facilities that accept chemically dependent women who are suicidal, manic, violent, psychotic, or dysfunctional, perhaps from drug reactions.

- Dental clinics that accept women for emergency services.

- Temporary shelters for women and/or children that accept persons who have been sexually assaulted, physically abused or threatened, locked out of a house, or otherwise left without housing.

- Protective services and temporary foster care placement services for children who have been abused, neglected, or need temporary care during a mother's emergency.

- Transportation services that can deliver women in need of assistance to their destination. These can include rescue squads, ambulances, police cars, volunteers, and taxicabs. Taxi fares can be prepaid from a petty cash fund.

Whenever a prospective drug treatment client is referred to a hospital, clinic, or psychiatric resource before the intake process is completed, it is important to establish that the woman will be referred back to intake after discharge or when the emergency evaluation is completed. Once the immediate crisis is resolved, further treatment for drug abuse may still be necessary. On some occasions, the drug treatment applicant will remain a primary client of the facility to which she was referred, but consultation between the two facilities can work this out. In other words, the intake unit has an obligation to track any applicant until she is firmly committed to a primary treatment resource, whether or not the intake process is interrupted by crises.

Followup on all referrals from the intake component can be accomplished if each case is recorded in a central referral logbook by date, with additional columns for the applicant's name, problem, consent for followup, referral resource contact and telephone number, and outcome status. An assigned intake worker should periodically contact the referral resources (e.g., hospital, detoxification center), provided that written permission was obtained from the applicant prior to the referral, and note decisions regarding any continuing need for the program's services or other outcomes. This activity requires time and commitment, but a regular review of the logbook can help document the frequency and types of crises encountered, the referral resources used, and their responsiveness or impact.

VERIFICATION OF ELIGIBILITY

The final step in preassessment screening is the verification of any required eligibility criteria. Each program should have clear and consistent procedures for this task. For example, it should state evidence required for applicant identification--birth certificate, driver's license, or only the statement of name. The staff must decide whether to validate other criteria such as age, residence, addiction history, or insurance eligibility. Whatever restrictions or criteria are set, they should be thoroughly explained to each applicant, and every effort should be made to specify what evidence will be needed before an applicant appears at the program.

During prescreening, the first program forms will be completed. These usually include four types of information:

- Basic registration information;
- Presenting problems and motivation for entering treatment;
- Summary of current drug abuse status and past treatments; and
- Consent to medical examinations (to be scheduled).

The woman applicant may be asked to complete the registration section while the intake worker enters notes on the other forms. If this is done, the applicant's ability to read and respond to the written questions should be appraised first, perhaps with the counselor explaining the form or completing it for the applicant, if preferred. Apologies do not have to be made for these forms, but the interviewer may wish to stress the importance of the information that will be requested and to explain how it will contribute to treatment planning and necessary referrals.

For some programs, this preassessment phase concludes the intake process and the eligible applicant is introduced to a primary counselor for further diagnosis, treatment planning, and orientation.

COMPLETING THE DIAGNOSTIC ASSESSMENT

The second and major phase of intake, following the preliminary screening and registration of the applicant, is the complete diagnostic assessment. Several methods are used during this phase to gather and confirm information from diverse sources in order to examine the woman's strengths and weaknesses. Each treatment program must design an individualized assessment protocol that is appropriate to its therapeutic objectives, staff resources, and applicant group characteristics. The following subsections provide guidelines for this process that parallel necessary decisions in four areas:

1. What information-gathering methods will be used for assessment?
2. In what sequence will data be collected?
3. What forms and format(s) will be used to record information?
4. What focus areas and specific questions will be covered in the diagnostic process?

ASSESSMENT METHODS

Intake assessments usually entail four methods that complement each other, help assure the accuracy of the data collected, and contribute to a richer understanding of the whole woman. These methods are as follows:

- Interviews with the applicant, family members, or other involved resources, using both structured questions to gather a comparable data base of similar information on all respondents and open-ended questions to elicit more personalized information;
- Tests to augment the interviews by laboratory examination of bodily specimens, measures of physical status (e.g., blood pressure, weight, temperature), or measures of psychological functioning (e.g., paper-and-pencil tests scored against norms established for similar populations);
- Observations of the physical body (through medical examinations by the doctor) and of the individual's personality characteristics (expressed in behaviors, speech patterns, and appearances noted by the interviewer); and
- Review of records that have bearing on the topics under study and are forwarded, with the expressed consent of the applicant, from other sources such as previous treatment programs, other community agencies, schools, criminal justice system representatives, or health care clinics.

The primary differences in these assessment methodologies are outlined in exhibit 2.

EXHIBIT 2.--Differences in assessment technologies

Assessment Methods	Procedure	Accuracy
Interviews	Involves guided interactions between the interviewer and the respondent.	Depends on rapport established through skill of the interviewer and positive attitude of respondent.
Tests	Compares individuals with group norms established by other raters.	Depends on reliability/validity of the test with a similar population.
Observations	Compares individuals with group norms established through the observer's own experiences.	Depends primarily on the astuteness and experience of the observer.
Records	Provides another person's perspective on same applicant's behavior or characteristics.	Depends on the correspondence between information in the same categories.

Guidelines for eliciting information in the interview follow.

1. Start the interview with a clear introduction. State the purpose of the interview; provide assurances that confidentiality will be protected by saying how records will be documented, stored, released, etc.; estimate how long the interview will take; and offer to stop for a break if the respondent tires. Also, introduce each new section of the interview with a brief explanation of its content and purpose.

2. Tailor the beginning of the interview to the special concerns of the applicant. Try to determine the applicant's emotional status from the presenting problem(s) and then begin the interview with a related focus. If she appears reticent and reserved, start with the least threatening or anxiety-provoking material, such as educational or medical history. Move right into relationships or legal problems if the applicant is primarily concerned with these issues. In an emergency, obtain crucial core data as rapidly as possible from any available source.

3. Respect privacy or a refusal to respond. Be sensitive. Let the client know ahead of time that she has the right

to refuse to answer questions. Avoid questions that seem to embarrass of offend her by going on to other subjects and returning to the topic only when the applicant is more relaxed and comfortable. Do not probe when there is active resistance; this can be noted for a later counselor to investigate.

4. Set the tone for open communications and discussions. Be direct, candid, and casual in your approach. Try to stimulate free answers by asking open-ended questions that can't be answered by a simple yes or no, but don't let the responses wander aimlessly. Don't interject your own biases or comments as you phrase the questions.

5. Listen actively and attentively. Focus your attention on the prospective client to encourage her responses. Provide feedback about information and feelings expressed by acknowledging their reality and validity without sounding superficial or falsely reassuring.

6. Keep cool and control your responses. Remain patient and tactful, even if provoked by unwarranted hostility, resentment, or misunderstandings. Defensiveness and anger are not useful. The immediate task is to get the prospective client into treatment, not to change her behavior on the spot. Recognize your own feelings of frustration or anger, but become comfortable enough with the situation to channel them appropriately without succumbing to arguing, scolding, or making sarcastic remarks.

7. Watch for symptoms of drug reactions. Recognize the potential impact of drugs on the applicant's responses, noting variations in behavior or mood swings during the interview that may reflect different states of intoxication and withdrawal. The overall validity and accuracy of the responses should be questioned if the applicant is obviously "high" or sick.

8. Phrase questions to evoke useful and accurate responses. Use simple language and ask brief questions, one at a time. Be as specific as possible about the timeframe or the context of the answer you are soliciting and repeat the question a second time, in a different way, if the applicant has difficulty understanding it. Know the content areas of the questionnaire you are completing and pursue the essence of each subject rather than read each item perfunctorily from the form. Stop to record coded data for information systems such as CODAP; rough notes will usually suffice to document other questions until after the interview is completed, however. Stick to questions asking "what" and "how" rather than "why," leaving interpretation of causality for later therapy sessions.

9. Guide the interview around sensitive subjects. In some subject areas where applicants may perceive the questions to be pejorative or socially unacceptable, the interviewer may guide responses by suggesting "approved" answers. For example, a recent study found that obstetrical clients, when questions about their daily alcohol consumption patterns, tended to deny drinking problems altogether when they thought such a response would be more acceptable. When, however, the question was reworded to ask, "How much do you usually drink in a day? Would you say two six-packs?", the social drinkers immediately laughed and said, "Oh, come on--more like two cans." Those with high consumption patterns, in contrast, replied, "Well, yes, sometimes a few more . . . or less." Suggested responses in the high range or negative category may overcome usual denial and increase the accuracy of respondents (Sokol and Miller 1980).

   Similarly, women might drop their defensiveness or embarrassment about discussing sexual traumas if the interviewer approached such questions with a statement such as, "A lot of women who develop drug problems have had some bad sexual experiences such as rape or sexual molestation by relatives. Have you ever had any of these experiences . . .?"

10. Define the conclusion of the interview. A natural way to end the interview is with a brief summary of what happened, a description of what can be expected next, and an invitation for any last-minute comments or clarifications. The interviewer's perceptions of the interactions should be noted in the records. It may be important to a later therapist to know, for example, that the interview was of questionable validity.

ASSESSMENT SEQUENCES

The sequence in which information is collected during the intake process can follow several flow models, depending on the availability of staff and other mandated data-gathering resources either onsite or at other locations. Ideally, the findings from all diagnostic procedures should be coordinated at once before treatment plans are formulated and recommended. In smaller programs, the diagnostic data base is seldom completed before treatment is initiated because physical examinations are scheduled offsite, laboratory tests or psychological status results take days to return, and records from previous treatment episodes are not immediately available. Figure 2 depicts a typical flow chart for information gathering in a drug program.

The intake procedures are usually segmented and spread over several days to a month. Appointments for physical or psychological examinations are generally made with external contractors or community

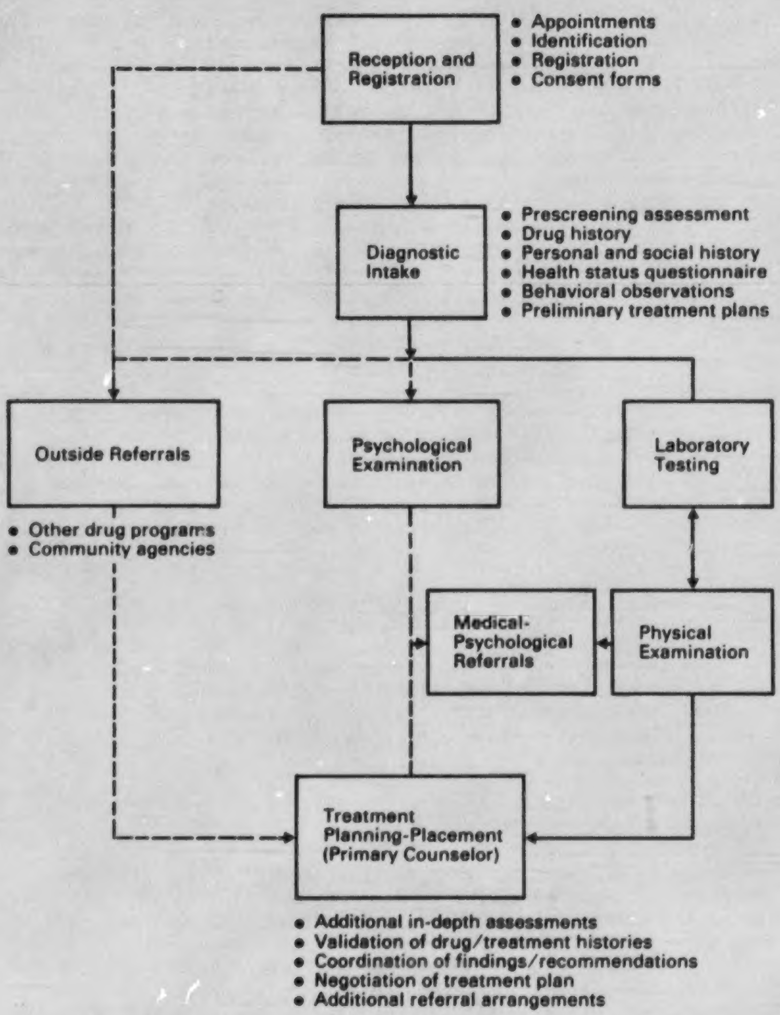
Reception and Registration
Appointments
Identification
Registration
Consent forms
Diagnostic Intake
Prescreening assessment
Drug history
Personal and social history
Health status questionnaire
Behavioral observations
Preliminary treatment plans
Outside Referrals
Psychological Examination
Laboratory Testing
Other drug programs
Community agencies
Medical-Psychological Referrals
Physical Examination
Treatment Planning-Placement (Primary Counselor)
Additional in-depth assessments
Validation of drug/treatment histories
Coordination of findings/recommendations
Negotiation of treatment plan
Additional referral arrangements

FIGURE 2. Intake flow chart

agencies, and findings may be delayed and difficult to track down. The intake component serves as a broker for referrals and appointments, whereas the primary counselor must coordinate findings and recommendations into ongoing treatment plans and modifications.

It is important to understand that the data base acquired to assess an applicant is not a limited information set but rather is a growing body of knowledge that is continuously expanded and modified as treatment progresses. Some programs can and will require that more facts be available before a placement decision is made, and each program may emphasize a different information base, depending on its treatment approaches. Decisions about the assessment sequence will necessarily involve related decisions about content: exactly what facts are necessary and available at which points during the intake procedures.

Programs that have a larger percentage of readmitted clients must also consider how to reprocess them most efficiently. Repeated physical examinations, for instance, may be unnecessary if the client is returning within the same year, but a health status questionnaire should be designed to note any new or emerging problems. If the original chart is available and can be carefully reviewed before the intake interview begins, repetitious collection of other historical information can also be eliminated in favor of new data on current problems and events.

DESIGN OF RECORDS AND FORMS

The forms and other records used by an intake component are an essential part of the clinical recordkeeping system and should be carefully designed to serve several purposes in addition to their diagnostic functions. Intake forms are used by treatment staff to continue the assessment process and initiate services, by the administrative section to measure the achievement of selected programmatic objectives, and by the evaluation team to determine client changes at discharge or followup. Staff representatives from these functional areas should, therefore, serve together on a program records committee with overall responsibility for design, review, and modification of all clinical records. In this task, the records committee can use not only the suggestions of other staff members, but also the three resource manuals published by NIDA:

- Clinical Record System for Drug Abuse Treatment Programs. National Institute on Drug Abuse Treatment Program Monograph Series No. 5. DHEW Pub. No. (ADM)78-689, 1978.

- Assessment Interviewing for Treatment Planning. The National Drug Abuse Center for Training and Resource Development, NIDA Training Division. National Institute on Drug Abuse, Rockville, Md., 1975.

- Drug Abuse Instrument Handbook: Research Issues. National Institute on Drug Abuse. DHEW Pub. No. (ADM)76-394, 1976.

This committee's decisions about intake records will involve the following:

1. Selection of the most appropriate of several specialized types of forms for client assessments, such as

    a. Client identification and registration form,
    b. Personal and social history form,
    c. Health and drug abuse status form,
    d. Physical examination form,
    e. Laboratory test results form, and
    f. Treatment admission summary and disposition form.

2. Selection or adaptation of supplemental forms that will assist intake procedures, including

    a. Registration logbook for applicant contacts and appointments;

    b. Referral logbook for followup of outside referrals to clinics, hospitals, medical exams, etc.;

    c. Client identification number assignment log with alphabetical cross-index;

    d. Routing slip to track the status of applicant's records during intake;

    e. Consent forms for medical procedures, methadone maintenance, release of records;

    f. Referral slip to accompany applicants when outside appointments are made; and

    g. Information sheets that describe intake procedures, program rules and regulations, etc.

3. Questions about the layout and formatting of the forms, including:

    a. Which questions should have forced-choice and coded answers and which will require narrative responses?

    b. How many carbons of each form are necessary and what is their distribution and schedule for transmittal?

    c. Where should the person completing the form sign and date it?

    d. Should space be left for summaries and comments by the intake workers and counselors?

4. Designation of focus areas, question content, and question order on the forms. (Further guidelines for this task are given in the next section.)

5. Directions for completing the forms should include:

   a. The staff member or consultant/contractor responsible for completing each intake form. In some recordkeeping systems, (see sample forms in the NIDA manual, Client Record System for Drug Abuse Treatment Programs, National Institute on Drug Abuse 1978), client assessment forms are structured so that crucial items are asked first in each categorical section of the interview. This basic information is supplemented by continuing interviews with the primary counselor that build on the initial appraisal.

Although intake staff members sometimes consider forms to be a nuisance, the time spent entering clinical observations and interview responses in the records helps diagnosticians to review, organize, and assimilate information and to make meaningful judgments and recommendations. Unrecorded information and impressions, furthermore, are lost to other persons who must treat the client. Intake assessments are a waste of valuable time and resources if more information is solicited than is used or if inadequate recording requires that another therapist must repeat the same questions later.

THE DATA BASE FOR DIAGNOSIS: APPLICANT INTERVIEWS

The major diagnostic interview conducted at intake usually has two parts:

1. A personal and social history covering the applicant's current relationships, responsibilities, living arrangements, legal involvements, and functional abilities as a homemaker, employee, student, financial manager, and recreational consumer/participant.

2. A health status questionnaire including an overview of the applicant's current physical condition, any significant history of illness or injury for her or her blood relatives, her current health practices, and a history of her reproductive and sexual functioning.

Portions of the information in these two assessments may be obtained through self-administered forms, provided that applicants can read and understand the questions and won't be embarrassed to ask for assistance. When this procedure is used, the completed questionnaire is still reviewed by the intake worker, who asks additional or clarifying questions to corroborate responses.

The diagnostic interview assesses the woman's strengths, sources of support, weaknesses, and needs so that the counselor can make valid treatment recommendations and referrals. The interview also allows the counselor to engage the applicant in a prolonged conversation and to observe nonverbal behaviors and communication patterns. While completing these health and social histories, the intake worker must be sensitive to both what is and is not said and must also continuously relate the information to potential solutions for the applicant's immediate and long-range problems.

The focus areas can be structured in many ways, and the questions for each section can be phrased differently. Not all focus areas are appropriate for each program, and not all questions are appropriate for each woman. Some programs, for example, prefer to group all questions about childbirth, sexuality, and menstrual functioning in one section, which is administered by the intake worker. Other programs may leave the medical history to a nurse in the physician-examiner's office but cover the questions on sexual functioning in the diagnostic intake interview. The rationale for the question groupings or focus areas is as follows:

- The Personal and Social History Form

  --Current relationships and living arrangements. The first section of the interview examines the immediate social situation of the applicant and focuses on support systems used (i.e., for emotional or practical help); responsibilities for children or other dependents; ways her drug abuse is affecting those around her; and crises or problems she views as important. This information will help the intake worker decide whether to recommend structured supervision during treatment or less intensive approaches.

  Is the female applicant lonely, isolated, or overwhelmed by awesome responsibilities? Is she living in depressing circumstances or blaming herself for the problems she faces? Is child abuse or family violence evident? Does she have a strong sexual preference for either men and/or women? Are there marital stress, estrangement, custody, or child support payment problems? Is a family member, partner, or friend willing to become involved in treatment? Does the applicant agree to this? What is her concept of the helping relationship?

  --Family background. The family history of illness and psychological disturbance (found also in the medical/psychiatric history and not repeated here) should be explored for any immediate effect on the applicant. Was there physical abuse in the family that makes her more prone to harm or neglect her own children under stress? Was addiction as a coping mechanism learned from an influential parent or other role model? The woman's attitudes toward authority, her sex role orientation, and feelings of acceptance or rejection probably stem from family patterns and will be useful in selecting a treatment environment and a counselor. For example, a young woman who is a school dropout and runaway with overt hostility toward tight controls may not do well in a traditionally structured therapeutic community. Similarly, the traditionalist woman may not accept a feminist counselor but may also have difficulties with a male she perceives as exploitative.

--Coping styles and self-esteem. What is the overall demeanor of the applicant and how will her coping styles affect participation in treatment? Does she deal with the world through anger and hostility or depression and withdrawal? Does she feel she exercises some control over her life and can take responsibility for getting better? This section will be used with other behavioral observations to assess the emotional status of the applicant and make preliminary determinations about psychological functioning. Is the applicant's behavior within a normal range for the population seen, or should she be reevaluated by a consulting psychologist or psychiatrist?

--Education and skills. Whether or not the applicant is currently working, she needs skills or an education that will qualify her to earn a decent wage. Does she have this ability? Would she be willing or able to go back to school or for training? What are the options and obstacles for this decision?

--Employment, income, and money management. The financial resources of the applicant and how she manages them may be a major concern in determining treatment placement and in the success of the therapeutic effort. Is the woman destitute or does she have an adequate income? What is the source of the income and how secure is it? Is she self-sufficient or dependent on another person, a welfare check, or other benefits? Could she become self-supporting in the near future? Has drug abuse interfered with her job now or in the past? Is immediate supplemental income assistance required? Will she need counseling in financial management?

--Legal status. Has the applicant been involved with the law because of drug abuse? How serious is the problem, and how might the charges affect her placement? Does she need an attorney now? Are there reporting requirements to other agencies because of legal involvement?

--Recreational activities. The use of free time is often a problem for women who have too little of it because of childcare responsibilities, too little money to spend on themselves, or don't know how to have fun without drugs. The activities that the applicant enjoys now or in the past are clues to her treatment needs. Social relationships may be difficult for her to initiate, or she may not know how to be alone and enjoy privacy. Will she need to build a network of new friends and activities to escape from addiction? Did she once participate in more wholesome activities?

--Other supports and barriers to treatment. The applicant may be involved with other social or counseling agencies and organizations with which the treatment program may need to communicate and cooperate. She may have additional barriers to treatment not yet disclosed or discussed. These should be explored before referral recommendations are made. Access to a private car or time limits set by a job may well influence the choice of a treatment program.

- The Health Status Questionnaire

--Current medical and psychiatric care and prescription medications. Is the applicant currently under the care of a doctor or therapist, and does she have any immediate health problems requiring care? Does she take medications, and if so are they abused? Will medication taken affect urine surveillance or further prescription of drugs? Will any chronic physical or psychological problems interfere with treatment, such as a work-limiting disability?

--Record of past illnesses or injuries. What past illnesses or injuries in the applicant or her immediate family may contribute to her current condition or attitude? Is there a family history of alcoholism, mental illness, cancer, diabetes, or other problem that is significant?

--Current symptom checklist. Does she have problems or complaints that need immediate medical attention (pregnancy, communicable disease, scheduled surgery)? What constellation of current symptoms does the applicant describe, and do they indicate withdrawal, addiction, serious illnesses, depressive reactions?

--Current health practices and attitudes. How much does the applicant's lifestyle contribute to her health status? Does she eat well, sleep or exercise sufficiently, or have irregular habits? Will she need further nutritional assessment or help with her appearance? Does she care about her body and her health?

--Reproductive and sexual functioning. Is the applicant functioning normally in this area? Does she need help with birth control, attitudes about sex, or guilt about prostitution or other sexual experiences? Has her drug abuse masked her feelings about herself as a woman?

THE DATA BASE FOR DIAGNOSIS: OBSERVATIONS AND EXAMINATIONS

In addition to the interview, appraisals are made of the applicant based on close observation and examination. Physical condition is determined through an examination. Psychological status is further assessed from other behavioral observations.

The Physical Examination. The Federal funding criteria require a physical examination to be administered by a qualified person as soon as practicable but no later than 21 days after admission. The purpose is to detect any serious illnesses and contagious diseases; to investigate the potential influence of a medical condition on treatment placement and outcome; to refer individuals to the health care system, as necessary; to confirm the drug abuse status and history; and to offer women a complete obstetrical/gynecological examination. Chapter 6 in this volume describes the necessary procedures for conducting a complete physical examination.

Behavioral Observations. At the conclusion of the diagnostic interview, the intake worker should take a few minutes to summarize and note important observations about the applicant. The purpose of these behavioral notations is to reflect on any symptoms of severe disturbance that will need closer investigation or immediate intervention and to distinguish those from other actions or eccentricities that may be, at least temporarily, harmless. This is the time to reflect on suicidal intent and to note bizarre costumes and mannerisms, for example, or threats of violence and signs of child abuse.

Behavioral observations are commonly noted in three categories:

- Dress and general appearance,
- Demeanor and behaviors, and
- Speech patterns and content.

Peculiarities or inappropriateness of dress are expressions of general attitude toward the world. Depression may be accentuated by poor grooming; prostitution flaunted by seductive clothes; self-concern and preoccupation manifested in flamboyant clothes; obsessiveness by fastidiousness. External appearances are also clues to socioeconomic level or expectation.

Behaviors are even more revealing. Again, depression is usually accompanied by fatigue and immobility or slowed reactions. There may be difficulties with attention and concentration or rage and anger directed toward various significant others or the intake staff. Many symptoms will be drug- or alcohol-related, and it may be hard to distinguish between the chemical effects and psychological symptoms. The applicant with no obvious clinical effects from a specified recent drug ingestion at a confirmed high dosage is probably tolerant and stabilized on that dosage. The drug-abusing woman may be agitated from "speed," "nodding out" from narcotics, or "tripping" on hallucinogens. Or she may be physically sick in withdrawal, showing numerous overt symptoms.

Behaviors combined with speech patterns and verbal messages are clues to suicidal potential, violence, or psychological disturbance. The inexperienced intake counselor may be uncomfortable about summarizing these observations and feel inadequate as a psychiatric diagnostician. Training and consultation from a professional clinician are strongly recommended in learning how to conduct and document a mental status summary. Caution is advised about concluding that disturbances are drug reactions or psychological impairments until the applicant has been drug free for 5 to 10 days.

Several resources are available to help with staff training in this area, but none is an adequate substitute for direct supervision and consultation. Two basic references in this area are

- Freedman, A. M., and Kaplan, H. I., eds. Diagnosing Mental Illness: Evaluation in Psychiatry and Psychology. New York: Antheneum, 1972.
- McReynolds, P., ed. Advances in Psychological Assessment. Palo Alto, Calif.: Science and Behavior Books, Inc., 1971.

Intake workers should give special attention to the following problems or disturbances presented by chemically dependent women:

Suicide Potential. The high-risk potential suicide victim perceives a current problem as intolerable, feels hopeless or helpless about resolving the problem, and is overwhelmed by despair. She is usually under stress from a severe loss in a relationship, job, social status, or health; and she shows depression symptoms such as social withdrawal, apathy, despondency, and exhaustion. The danger increases if there is simultaneous agitation or bursts of anger and a specific plan for suicide involving a lethal method, available tools (e.g., pills, a gun), and an action plan.

Violence Potential. Women commonly take out their frustrations and rage on themselves, directing anger into suicide rather than harm to others. Children or dependent parents and relatives or even spouses or partners may, however, be at risk from a woman's violence, particularly in highly stressful situations that have few approved outlets for her hostilities. Physical or emotional assault may take place in self-defense, in retaliation, or as vengeance for a perceived wrong. The woman may exhibit overt rage only under the influence of drugs, or she may have threatened harm to someone during the interview. Expressions of violence, anger, hatred, threats, and past harmful actions should be carefully documented and assessed for potential misdirected harm to others, especially children.

Psychosis Potential. Gross disturbances of function resulting from schizophrenia, chronic brain damage, manic depression, or paranoia may be observed in a few women applying for treatment. Disorders of thought patterns, intellectual functioning, or sensorium are manifestations of these psychological or intellectual problems. The most usual symptoms to note are the following:

- Form disturbances (thoughts are not reality based)

  --Hallucinations are any auditory, visual, or tactile perceptions that have no external cause or stimulus.

  --Delusions are false beliefs without external evidence.

- Stream disturbances (thinking shows abnormal associations)

  --Blocking occurs when the person can't complete an idea and stops abruptly in midsentence.

  --Tangential thinking happens when the goal of a thought is never reached and speech wanders.

  --Perseveration is shown as persistent repetition of the same idea.

  --Incoherence is demonstrated when there is no logical sequence but only fragmented ideas.

  --Flight of ideas is manifested in a manic, high-speed flow of speech with illogical progression.

- Orientation disturbances (of the sensorium)

  --Time/place/person disturbances occur when the person doesn't know the month, day, year, geographic location, or names.

  --Memory disturbances are shown when memory is lost for recent or remote events.

- Neurological disturbances (may indicate brain disorders)

  --Eye-hand coordination problems and clumsiness;

  --Partial paralysis on either side, with limping gait and/or claw-like hand;

  --Speech difficulties in formation of words (slurring, flat articulation) or producing correct names for objects or persons; or

  --A focus on concrete descriptions with inability to abstract or reason symbolically.

USE OF OTHER INFORMATION SOURCES

Occasionally intake interviewers pose questions that can't be answered by the applicant, or large gaps and inconsistencies may be found in the information gathered. The applicant, for example, may not be able to remember much about a previous treatment episode, such as what medications were prescribed, what the focus was for therapeutic intervention, or why treatment was terminated. She may give inconclusive responses to questions about her drug history, the diagnosis of a family member's severe illness, or her own attitudes and behaviors toward her dependent children. The intake worker should fill in such gaps or resolve fundamental inconsistencies whenever possible by using other available information sources. Friends and relatives of the applicant are particularly valuable for confirming the addiction history and giving a new perspective to other points in the social history (e.g., the current living situation and childcare relationship patterns). Programs should establish routine procedures for soliciting interviews from at least one source other than the applicant. This may not be possible at the point of first contact or intake but can be arranged as soon as the applicant gives her consent.

Personnel from other agencies may also be queried for specific information that seems crucial to the intake process (e.g., the discharge date from a previous treatment enrollment and the reasons for dismissal). Each contact with an outside resource will require a separate consent form signed by the applicant that specifies the reason the information is needed, the purposes for which it will be used, and the date or conditions when the release permission expires.

Records of previous treatments are particularly valuable resources for verifying clinical impressions and checking the consistency of responses to drug histories and other biographic history. Records also help the worker determine which treatment settings would be most appropriate and which intervention approaches succeeded or failed and why. Consent forms should be requested routinely from the applicant so that this information can be obtained.

THE DATA BASE FOR DIAGNOSIS: TESTS

Two kinds of tests are frequently administered at intake to supplement and corroborate the other diagnostic information:

- Laboratory tests of blood, urine, and specimen smears to verify drug abuse status and to detect other significant physical abnormalities; and

- Psychological tests to determine or confirm severe pathology for subsequent referral to more intensive mental health care or to obtain baseline data on personality traits that may affect treatment planning and become the focus for change by therapy.

Psychological tests, for a variety of reasons, are not required nor routinely ordered by all programs as a part of the intake protocol. First, temporary effects of drugs tend to mimic manifestations of psychopathology, and it is usually difficult to distinguish one from another until a woman has been completely detoxified and stabilized (at least 5 to 10 days after admission). Second, test validity for addicted women (especially subgroups of minorities, economic classes, or age brackets) is not well established for many instruments, which makes interpretation of the findings highly suspect (Tucker and Douvan 1976). Third, many programs do not have a psychologist available on staff as a regular consultant to administer and interpret tests or to conduct interviews.

Programs that do administer psychological tests at intake should use extreme caution in their selection, scoring, and interpretation. A trained and experienced professional clinician is the first requirement. Programs should also note how much time and expense goes into testing in comparison with the results achieved. A good discussion of some current standard tests and instruments can be found in Waskow and Parloff (1974).

A few short paper-and-pencil tests exist that can be self-administered by the applicant or conducted by a trained nonprofessional, easily scored, and reliably interpreted. Some of these are nonthreatening and may be revealing and interesting for applicants to take, although they may be more appropriate during a later phase of treatment.

Two tests that may be particularly useful during the diagnostic process to determine potential alcoholism are the Michigan Alcoholism Test (MAST) and the Alcohol Stages Index (ASI) or Mulford test.

The MAST is a 24-item objective questionnaire and takes only 10 to 15 minutes to complete. It asks about drinking practices and social effects and has been widely used and publicized as a screening mechanism for problem drinkers and alcoholics in the general population. Although it was developed with institutionalized male groups, the test has been found to be effective for both sexes. Males do score higher than women on 7 of the 24 questions that relate to their more typical behaviors such as drinking and driving (Selzer et al. 1979). A shortened 10-item version of this test is known as SMAST and has also been widely used. It is not, however, as discriminate for women as for men. Either test can be offensive and invalidated by untruthful responses; both tests should be corroborated by other sources, if possible. Further descriptions are available in Selzer (1971) and Porkonny et al. (1972).

The ASI was developed by Mulford as another standardized alcoholism screening instrument for general application. It has been refined over a 20-year period and has four discrete subscales on behavioral, attitudinal, and drinking consequences phenomena. The subscale on personal effects is particularly sensitive to the behaviors of women. This test views alcoholism as a progressive, multidimensional process, and its subscales are more discriminate than SMAST in identifying and classifying alcohol abusers without too many false positives. Preliminary findings in research with employed women show the Mulford to be a more appropriate instrument than SMAST for identifying problem drinking and alcoholism in this group. Further discussion can be found in Mulford and Wilson (1966) and Mulford (1977).

MAKING RECOMMENDATIONS AND REFERRALS

At the end of the diagnostic intake process, the intake worker synthesizes findings into treatment recommendations and negotiates with the applicant concerning primary placement in a treatment setting that will provide other necessary supportive services. This section discusses the steps and requirements for a satisfactory completion of the diagnostic assessment:

- The summary of findings and recommendations,
- Concurrence on recommended referrals,
- Negotiation of placement(s), and
- Arrangement and completion of referral(s).

Programs will differ in the frequency that their applicants are accepted and placed for initial treatment within their own environments or referred to other resources for primary services. The procedure is essentially the same, however, whatever the placement decision.

SUMMARY RECOMMENDATIONS

At the conclusion of the final diagnostic interview, the intake worker is ready to review and sift through all of the available data gathered by different methods and from separate sources. In some programs this will include only the screening information and the personal and social history; elsewhere, the health status data will also be present; and in some programs, the results of the physical examination will be ready.

The first step is to summarize each subsection or focus area of intake information, noting the applicant's relative strengths and weaknesses. This may be done in narrative notes on the forms themselves or on a separate note pad. The counselor should consider, for example, such areas as drug abuse status, family situation, available support systems, and health care needs. Preliminary impressions and immediate recollections can be documented first, with more specific comments drawn from a review of the questions and responses.

The next step is to relate available facts and impressions to each other to discover and reconcile any discrepancies. Does the recent drug use history support, for instance, the symptoms reported by the applicant and those also observed by the interviewer? Is this evidence further confirmed by the drug toxicology and the doctor's physical examination? A finding of morphine (heroin) in the laboratory urinalysis report with "tracks" and recent needle marks noted in the physical examination should be corroborated by the applicant's history of a recent heroin injection and some physical evidence of toxicity and withdrawal, depending on the dosage level, duration of the abuse pattern, etc.

If discrepancies in data do arise, an attempt at resolution should be made immediately--first among the intake staff and then with the applicant herself or available relatives and friends. There is no need for confrontation or challenge if an inconsistency is found because this will only heighten the applicant's defensiveness and ambivalence about treatment. Many mistakes occur that may be resolved with a few questions and explanations. Laboratory and physical examination findings are not without their mistakes either. In some cases, however, more detailed questioning involving the family and friends, if appropriate and approved by the applicant, may be necessary before mutual agreement is reached on the facts in a given situation. This is usually the case when the applicant is on drugs at intake and very casual about answers, perhaps to test the concern of the intake staff.

After each category of information is summarized, the major strengths, supports, and problems and needs that were identified can be transferred to a planning matrix format similar to the one below.

Focus Area	Strengths/ Supports	Problems/ Needs	Recommendations (by priority)
Physical health			
Drug/alcohol status			
Drug treatment history			
Current relationships			
Living arrangements			

Recommendations for each focus area should consider the different time requirements for intervention strategies. Urgent and immediate needs should receive priority in the initial phase of treatment, and less persistent problems should be deferred to a later phase of treatment. The systematic approach to referral developed for treatment of polydrug abusers in a community network of services is a relevant intake model (Comstock and Dammann 1977). This system advocates, first, "attention to immediate needs, followed by efforts to correct for damage done to the individual by drug involvement, and finally ending with restoration to baseline functioning and progression on a course of individual growth." In other words, the different steps of treatment from crisis through short-term stabilization to long-term rehabilitation and growth will coincide with different goals and assistance needs. The woman at intake must have her most basic problems with physical pain, lack of food or shelter, financial destitution, psychological trauma, etc. met before she can become involved in more therapeutic aspects of treatment, long-range planning, and self-sufficient functioning.

On the planning matrix, for example, the relationship category might note that the applicant gets supportive help from her original family in the form of occasional childcare and financial assistance (support), but that she has been abandoned by her husband and is currently living with an abusive addict-pimp whom she is afraid to leave because of threats of violence (immediate problem). The recommendations section might suggest immediate referral to a residential center that accommodates children under 6 years old (the applicant has two in that category), although the woman also has a 10-year-old son. The expectation would be that arrangements could be made with the family to supervise the son temporarily while the mother was in residence. In the final recommendations, other factors such as employment and severity of the drug problem would also be considered in selecting a primary treatment placement. The recommendations for each subsection should indicate whether services are needed urgently before a primary referral is completed (e.g., hospitalization for medical complications), immediately during initiation of treatment (e.g., money, food, shelter, outpatient medical care), or in the future, after treatment has been stabilized and rehabilitation efforts continue.

After the summary is completed, the diagnostic counselor will determine the most appropriate primary resource among the treatment agencies or program components available. A preliminary treatment plan will be outlined, stating the rationale for the recommended facility/program and delineating other support service referrals that should be made and their level of priority, from immediate and urgent to secondary and supportive.

Several interrelated factors must be considered in deciding whether the primary placement recommendation will be within the program conducting intake or with another referral resource. Essentially, the applicant's immediate needs must be matched to the program's capabilities.

When preparing initial recommendations, the intake worker should focus first on the treatment environment that appears most appropriate, second on the therapeutic approach that seems most likely to succeed, and finally on the supportive services that will be needed immediately. The realities of availability and eligibility will then intercede and compromises can be worked out. It is unlikely that any one program will be able to provide all necessary services over the full course of treatment, but the primary placement should be with the one that is able and willing to provide the most urgent services first and also to take responsibility for all later referrals.

CONCURRENCE ON RECOMMENDED REFERRALS

One of two strategies is appropriate for planning and recommending treatment placements:

- A decision-review process, or
- A miniteam conference approach.

Each has advantages and disadvantages, as shown in the following chart:

Approach	Advantages	Disadvantages
Primary intake worker decides, supervisor reviews	Relatively quick	One person decides and may be overruled
Team conference recommends	Multiple professional opinions and judgments expressed	Procedure may be cumbersome and time consuming
	Assures individualization of treatment planning	Consensus may be difficult to achieve
	May inspire advocacy for new services	

In some programs, one diagnostic counselor pulls together all facets of the intake information and makes all initial suggestions and referrals, which are reviewed later by a supervisory administrator. The advantage of this approach is speed, but the disadvantage is the inconvenience or harm done to the applicant if a poor recommendation is made and later reversed by a review team. In other clinics and programs, a "miniteam" of staff members from different professional disciplines can be quickly assembled to review or make suggestions on unusual or difficult cases. This approach helps assure that no alternatives are inadvertently overlooked. When this process is too formalized, requiring a case presentation, for example, the procedures may tend to become cumbersome and burdensome. Consensus on recommendations may be difficult to achieve when workers have different perspectives on preferred treatment approaches for certain types of clients. Discussions and arguments are useful to assure the individualization of treatment planning and also to focus staff attention on the gaps in available services in the community. When the same referral problems occur repeatedly, the problem may not be agreement on what is needed but rather inadequate or unavailable resources. In such situations, intake workers may wish to form advocacy alliances with other interested groups and try to work for changes and improvements in the existing treatment network.

NEGOTIATION OF PLACEMENTS

After staff agreement is reached on a preliminary treatment plan and a primary placement resource, the diagnostic counselor presents these recommendations to the applicant. If the interviewer process has been one of mutual exchange, the referral recommendations will not come as a surprise, because the merits and liabilities of different treatment modalities and environments will have already been discussed with the applicant.

In addition, while the diagnostic counselor has been preparing an intake summary and tentative treatment plan, the applicant may also be reviewing her needs and learning more about available community alternatives for treatment. This process can best be assisted by a looseleaf catalog of resources indexed by service area (e.g., medical services, psychological services, social services for specific needs, legal services). The catalog should also contain a section on the primary placement resources for treatment of chemically dependent women. The catalog is a ready reference tool for intake workers and applicants alike; it can be compiled and regularly updated by board members or a volunteer group if staff time is limited. The following information should be available:

- Name and address of program and name of contact person;
- Brief overview of program's goals, range of services, treatment components, phases of care, hours of operation;
- The number and qualifications of staff and the number and typical characteristics of clients;
- Agency rules and regulations regarding attendance, minimum/maximum length of stay, medications/abstinence philosophy, urinalysis requirements, and participation expectations;
- Program eligibility requirements for age, sex, race, geographic location, substances abused, etc.;

- Client's rights and the reasons for discharge or dismissal and the procedures for appeal; and

- Costs and fee schedules.

The applicant, in using such a catalog, should first select a primary treatment placement that appears to offer the basic core of services she thinks she needs. Later she can consider supplementary assistance she might need in the near future. Scanning a catalog of resources, the applicant may gain some interesting insights--she may have forgotten earlier positive or negative experiences with the resources listed and be prompted to recount them.

The diagnostic counselor may present staff recommendations regarding treatment to the applicant or may simply discuss the alternatives and choices until a mutual agreement is reached. Whatever the presentation style, the woman entering treatment must know that she is intimately involved in the planning process and that the final responsibility for the selection of a suitable resource is hers. Whenever possible, members of her family and/or her partner should be available for the final negotiation of a placement so that they know what is involved and how they can best cooperate. Ideally, a representative from the selected treatment program or component should also be available to offer an orientation and answer questions.

COMPLETING THE REFERRAL PROCESS

The steps necessary to complete the referral process and initiate treatment will depend on whether the placement is made within or outside the program containing the intake unit. Internal referrals require no consent forms and are easier to arrange. A telephone call may summon a counselor who can be immediately appraised of the intake findings and the preliminary treatment plan.

Outside referrals are more complex. The selected agency or program that will be the primary treatment resource should be contacted first. The intake findings and recommendations concerning the applicant should be realistically discussed, including special problems. Consent from the applicant will be necessary to transfer specific information and to discuss the applicant's situation with the selected agency. If resistance to the acceptance of the applicant is encountered at the agency, some bargaining and convincing may be necessary; it is often wise to do this outside the applicant's hearing. Suggestions for supplementary support should also be made to the selected agency as part of the negotiation process. Perhaps the agency will accept the applicant if she will detoxify first in another facility, or if the intake unit will refer her back within 2 weeks if the placement doesn't work out. Creativity and persistence on the part of the intake counselor can work miracles, but only if the contact with the agency is personal, honest, and continuous. A mechanism should be established by the intake unit staff for regular and periodic contacts with all the primary resources they use. This might take the form of a council of agencies that meets to exchange information and discuss problems or a newsletter that provides another forum for information exchange and announcements of program or staff changes.

The discussion with the primary referral agency or component about the treatment recommendations should include plans for other supportive services that are needed immediately (e.g., childcare, transportation, dental care, birth control devices). Concurrence should be obtained about the necessity and priority for such services and how they will be arranged and monitored. These suggestions may seem to usurp the primary counselor's treatment responsibilities and be an invasion of his/her arrangements with the client, but the purpose of intake is to provide this initial objective overview of applicant needs. The intake unit cannot assume ongoing responsibility for supplementary referrals and, therefore, has the obligation to inform the primary counselor of problems that have been discovered. Further conflict between intake and the duties of the primary counselor will ensue if the intake unit tries to monitor the provision of support services, whether medical or social service referrals. The new client must be completely transferred to treatment at this point, with all intake information and any forthcoming test results forwarded to the primary counselor. Feedback that the transfer has been successfully accomplished is all that is required.

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4.
The Process of Counseling Drug Dependent Women

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This chapter will give counselors of chemically dependent women an overview of the issues involved in establishing and using a counseling relationship. We will examine the special problems of the chemically dependent woman in treatment and suggest a counseling approach responsive to these problems.

In this chapter, we provide an overview of the counseling process and illustrate how the counselor can plan, sequence, and pace his/her work with a client. A special focus is the counselor-client relationship and strategies for identifying and working with resistance and barriers to change, both internal and environmental. The need for counselor support and good supervision is stressed.

The women described have a history of dependence on heroin, and may or may not have used other substances as well. Although we do not address the treatment of women dependent on prescription drugs or alcohol, much of the how-to-do-it information will also apply to counselors who serve such women. The phases of counseling, the roles of the counselor, and many of the issues discussed are also appropriate concerns in counseling chemically dependent men. Many of the counseling issues referred to in this chapter are explored in greater depth elsewhere in this book.

ROLES OF THE COUNSELOR

WOMEN WITH MANY PROBLEMS

The roles assumed by the counselor and the nature of the counselor's relationship with the chemically dependent woman are influenced by the type and severity of the client's problems and the background and experience of the counselor. Chemically dependent women entering treatment present chronic and multiple problems. Over and over, the image evoked in the literature is one of women with numerous problems. Addicted women entering treatment are characterized as having low levels of self-esteem and high anxiety levels (Colten 1980b). Typically, they have more medical problems than addicted men (Andersen 1980). Despite having more family responsibilities, they often have fewer economic resources and support systems than addicted men do (Tucker 1980). Addicted women also appear to have minimal education (Binion 1980), and few job skills (Reed and Leibson 1981). Those who leave school early have been found by Moise (1979), to be more likely to become involved in prostitution and to have attempted suicide more often than addicted men. Moreover, as noted by Bahna and Gordon (1978), "The female heroin addict carries a double stigma of social deviance . . . it serves to magnify the negative self image of female ex-addicts, and in turn makes attempts at socialization during rehabilitation more difficult."

Our clinical observations support the findings in the literature. The following are examples of some typical problems presented by women entering treatment.

- Few vocational skills: "What can I do? Well, I don't really know. . . I've never given it much thought. When I was running on the streets, I hustled and turned tricks. But now, I have nothing I'm good at. . . I have no skills and no education. I never finished the 11th grade. I guess I would try and get a job working in a liquor store or maybe as a waitress. That's about all I would hope for."

- Few social supports: "Since my old man left, my Mama is the only one I turn to. She helps me out with the kids and is just there if I need someone to talk to. Even though we've had our differences, I know she'd always take me in . . . she's been good to me through all my ups and downs."

- Low self-esteem: "My Mama never believed in me when I was a kid. One of the things I remembered was when I came running to her one evening crying bitterly. I was 12 at the time. I told her that my 16-year-old brother and his friends raped me. I told this to Mama and she told me to shut up and stop inventing lies again. She always called me a liar. I grew up believing I was nothing but an irresponsible liar."

- Negative images of other addicted women: "I would never go to one of those rap groups with other women in my methadone program. Why, the women in those groups are all snakes. They're just junkies who will tear you apart in a minute. Why would I want to be around women like that?"

- Ambivalence about associating with "straights": "Although I probably could have associates who are straight, it's just not worth the hassle. I spent the other night with a straight man and in the morning I just couldn't face telling him that I needed to get my drink [methadone]. So I left without saying a word. It saved me the hassle of going through all that explaining."

- Complex domestic entanglements: "When my daughter's girlfriend came and told me that my daughter was sleeping with my old man, I nearly died. They had been doing this for 2 years right in my own house. I was so angry I got a gun and took it to bed with me that night swearing that if he came to me, I'd kill him. He never did and my anger cooled down. When I confronted my girl, it only got worse. She told me that Jimmy (my old man) was shooting her up with Ritalin and that she'd been prostituting for him as well."

- Commitment and loyalty to a man: "My old man is my pimp. He's 20 years older than I am, but I still support him. I know deep down why they tell me to leave him, but I won't give him up. I'd rather do time in jail before making the promise not to see my old man again. I've done this before. When I was charged with burglary, the DA offered me 3 years' felony probation and restitution if I'd stay away from Jim. He said that Jim introduced me to drugs and was the bad influence on me. That's bunk. I have a mind. . . I can say no. I refused the DA's offer and did my time in jail."

- Pessimism about the possibility of positive change: "That's just it, honey--things are not likely to change for me so I get to thinking, why bother in the first place."

- Mistrust of the treatment setting: "The contacts I've had with the courts and the welfare system have all been bad. They're all the same. They see me as a junkie or a hooker, they're always out with a 'holier than thou' attitude. You really have to be careful not to tell those people anything. I don't need to be told by someone that I made lousy choices in my life, especially by someone who just doesn't understand anything about what I'm going through."

- Multiple problems: Sandi, a 41-year-old woman, entered the treatment program requesting legal help to retain the custody of her 9- and 14-year-old sons. As the counselor began to work with her on this issue, she received an eviction notice and was severely beaten by her ex-boyfriend. While in the hospital, a tumor was discovered in her breast and surgery was required. She experienced all these crises within the space of 3 weeks.

When the counselors are faced with a multiple of needs and problems on a regular basis, they are likely to feel frustrated, confused, and even overwhelmed. In counseling chemically dependent women who are likely to be manipulative and have frequent setbacks, counselors may become disappointed and even angry about lack of progress.

Counselors need to understand their own feelings and to have a clear understanding of their role as helping persons. To clarify the

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range of the drug counselor's activities, we will examine the five basic roles of counselors who work with chemically dependent women and how these roles are interrelated. These roles are

- Limit setter,
- Advocate,
- Treatment coordinator,
- Educator, and
- Therapist.

The emphasis each role receives depends largely on the specific needs of the client. Counselors will feel most confident if they have developed skills in each role, moving from one to another in carrying out the treatment plan. This expectation may seem overwhelming to many counselors, but the intent of these role definitions is not to push counselors toward becoming experts in five careers at once. Some fundamental skills, procedures, and techniques in each area can be learned in a relatively brief period.

LIMIT SETTER

Limit setting is an integral part of all relationships, especially therapeutic ones. In a drug treatment program, counselors convey and enforce not only their own personal and professional limits but also those of the program. They confront the clients when rules are broken and clearly convey their expectations that the clients will participate actively in the treatment process. Counselors assess and react to inappropriate behavior by clients, constantly challenging manipulative behavior and communicating limits. For example, in accepting a court referral, a counselor might point out that the client must adhere to the rules governing her probationary status. If the client is suicidal or physically harmful to her children, the counselor may have to secure the aid of responsible agencies such as child protective services or a psychiatric hospital.

> Clarissa, a 26-year-old woman, was admitted to the drug treatment program involuntarily. The courts mandated that she either enter treatment or go to jail. Because Clarissa said that her motivation to stay clean was not that high, the counselor tried to focus on the consequences of her destructive behavior. When she began producing "dirty" urines, the counselor confronted her with the problem and reminded her of her probationary status. When it became clear that Clarissa had no intention of giving up drugs the counselor had to inform the parole department and her parole status was revoked.

Although the counselor must act authoritatively at times to stop a client when her actions are destructive to herself and others, limit setting should not be used indiscriminately as a punitive or social control measure. When limit setting is used for such ends alone, it is both inappropriate and ineffective.

A core element in limit setting is the counselor's sensitivity. The ability to set limits and help clients deal more constructively with their problems and change their lifestyles is derived from the quality of the client-counselor relationship. The client must sense that the counselor cares about her.

The client experiences the counselor's caring and support in a variety of ways, beginning with the empathy transmitted and the concrete, visible, and effective actions that improve the client's circumstances. Mere expressions of sympathy will not suffice. The counselor must be prepared to actively help the client find solutions to the many problems that confront her. The counselor must also work to understand the compelling nature of the client's needs and perceptions, even when they differ radically from the counselor's.

Before assuming a limit-setting role, the counselor should ask the following questions:

- How can limit setting convey that I will not allow myself to be manipulated in ways unhelpful to the client?
- How can limit setting convey that I respect the client enough to expect responsible behavior?
- How can limit setting convey that I find certain behaviors unacceptable because they lead to negative consequences?

When staff members define their expectations, clarify the limitations of the counseling relationship, and consider the client's needs as well as their own, they take the necessary steps for effective limit setting. Experience suggests that clients respond favorably to limit setting because they realize that the counselor is neither an unfair tyrant not a pushover.

> Cora, a 22-year-old woman, had been very cooperative at the beginning of treatment, but 2 months later she had used heroin two times in 1 week. Her counselor brought up the results of the tests, and Cora stated that depression and loneliness were the reasons for going back to her former friends and habits.
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> The counselor, without being vindictive or moralistic, said, "This just won't work. You're throwing away your chances of getting treatment, and I don't want to see you go on like this. I know you're depressed now, but I can help you get through it. I won't be able to work with you if you get thrown out of the program. You've got to turn in clean tests for the rest of the month, or you'll be facing a disciplinary hearing." The counselor urged Cora to ask a woman in her group to spend time with her on weekends, when she was most lonely.

Limit-Setting Techniques. The counselor should have an opportunity to practice, in training or with supervision, various limit-setting techniques and obtain feedback on the reaction of the person playing the client. The following guidelines used by treatment professionals and teachers in many settings should help:

- Be specific. Describe observations of actual behavior (say whose observations are being given). Say when, where, and how the behavior in question occurred. Focus on one instance (or pattern, if sufficient specific instances have been confronted to create a pattern), and do not bring up problems or issues that have no direct bearing.
- Do not allow the client to change the subject.
- Be sure that you do not attack the person when you confront the behavior.
- Do not generalize ("You've done this a lot" is not as effective as "This is the fourth time you've arrived late in 3 weeks").
- Listen to the client's perception of the problem, and empathize with her difficulty in complying with the rule in question.
- Make a statement about your willingness to help with this problem. Then, restate the limit in terms of a rule that she will have to obey.
- Describe the desired behavior in precise terms ("You will have to arrive within 5 minutes of the beginning of the meeting or you won't be able to attend").

ADVOCATE

The chemically dependent woman often has problems that cannot be adequately addressed in the treatment program. Because she often lacks assertiveness and the basic skills needed to negotiate for and secure services from a variety of community resources, the counselor will often have to actively intervene to help her. Such services may include welfare, housing, childcare, legal, medical, vocational, or educational assistance. In assuming an advocate's role, the counselor must constantly assess the client's capability to take the action by herself, for it is the counselor's goal to help the client function independently.

Often, with the client's permission, the counselor negotiates with a third party. Straightening out a personal problem, obtaining school records needed for employment, or securing a missing welfare payment are examples of actions that may be taken by the counselor. Thus the counselor consciously serves as a role model, showing the client how to be assertive in negotiating for services while giving her increased responsibility in the negotiation process.

The counselor may also assume an advocacy role when an individual or organization is unjustly persecuting, controlling, denying, or intimidating the client (Seabury 1980). In taking a position of active support for the client, the counselor may win the client's respect and appreciation, thus strengthening the client-counselor relationship. The advocate counselor may also serve as a teacher, demonstrating that the problems facing the client can be overcome by gaining new skills and knowledge.

> Linda, a 27-year-old woman, moved into a new apartment with her 6-year-old son. She requested assistance from her counselor when her cleaning and security deposit from her former landlord was not returned to her and she couldn't make her rental payments. The counselor looked into the matter and found that although Linda had receipts showing she had paid the deposit, her landlord claimed to have no record of the payment and refused to reimburse her. The counselor quickly moved to help Linda file in small claims court. She helped Linda prepare for the court appearance and assemble her evidence. Two days before the court date, the former landlord paid the money.

TREATMENT COORDINATOR

In this role, the counselor prepares the client for each aspect of treatment, negotiates a treatment plan with the client and other program staff, coordinates the program activities to obtain maximum therapeutic benefit for her client, and periodically assesses progress, revising the treatment plan where necessary based on current circumstances and needs. Through ongoing treatment planning and coordination, the counselor assures that services are individualized and that continuity of care is facilitated.

The treatment coordinator also secures information on resources outside the program that are needed by the client. Over time, the client's situation may require the assistance of agencies in both the public and private sectors in several specialized areas. For example, the services of specific individuals, such as medical specialists, lawyers, and vocational training personnel, are likely to be needed to meet specialized needs. The treatment coordinator's function is to help the client find the most appropriate resources available. Therefore, although the program may maintain files on community referrals, the treatment coordinator must also personally investigate potential resources through both formal and informal channels.

> Sally, a 37-year-old woman, suffered from severe hypertension. Although she adhered to a low-sodium diet and reported to take her medication regularly, her blood

pressure remained elevated. She was getting nose bleeds and severe headaches and began using heroin to alleviate the pain. The counselor consulted with several physicians and investigated services available in the community. After reviewing the various alternatives with the client, the counselor referred her to a physician who used biofeedback techniques. Sally, though initially skeptical about the usefulness of this approach, continued to go to her sessions. Her headaches disappeared, her blood pressure was reduced, and she also stopped "chipping" after 6 weeks of biofeedback therapy.

EDUCATOR

Counselors can often provide clients with new knowledge and teach specific skills. They may teach classes on parenting skills and child development or on sexuality. In individual sessions, they can help clients learn about the nature of depression and other emotional states, understand what to expect during the detoxification process, and look at problems in light of gender role expectations, social conditioning, and difficulties facing many women.

Counselors may also coach clients to fill out job applications, prepare for exams, or teach nutrition. The key questions for the counselor to ask before providing information or teaching new skills are as follows:

- Is this client aware of her need for this information?
- Is she in a position to absorb new information?
- Am I the most appropriate, readily available person to teach this person this skill?
- Is it possible to organize a class (or add this learning experience to an existing group) in order to create a better learning environment for this client?

Educational resources in the community may offer better quality instruction _and_ provide the client with a positive educational experience outside the treatment setting. But the counselor must determine whether the client would follow through on a referral to a class, and whether the skill or information would be presented in a timely or practical way. Often, it is more efficient to teach a specific skill in individual or group sessions that the client is already attending.

Jeanie, a 34-year-old woman, was having difficulty relating to her 12-year-old daughter, Claudia. She came into treatment requesting family therapy because she felt helpless dealing with Claudia's readjustment. Claudia had been living with her grandmother while Jeanie was in jail for 3 years, and now she rejected her mother's role as a parent. The counseling sessions were focused to help Jeanie enhance her parenting skills and to help her establish a better relationship with her daughter. In individual sessions, the counselor helped her find ways to control her daughter's behavior and set effective limits. She helped Jeanie learn to tolerate Claudia's angry reactions without backing down or overreacting. They also discussed appropriate behavior for 12-year-old girls, and the client learned that although her daughter's behavior was age appropriate, it had to be met with firm limits. To help her further enhance her parenting skills, the client was referred to a Parent Effectiveness Training workshop that was being offered at the treatment program.

THERAPIST

Probably the most challenging role for counselors is that of therapist. Techniques and approaches of the counselors performing this role vary, based largely on individual educational background and experience. In this chapter, therapy is defined as the development and systematic use of a relationship to initiate and guide a process that is designed to improve a client's specific areas of functioning and overall well-being.

As a therapist, the counselor provides ongoing guidance to the client based on an understanding of the client's needs, strengths, weaknesses, and resources. The counselor collects information, listens to and observes the client to understand her, and is available to provide support, guidance, and direction. The counselor enters into a social relationship with the client and provides an environment in which she will feel comfortable enough to discuss her concerns, problems, and needs. Empathy, intuition, and knowledge of human behavior are used by the counselor to understand the client's feelings and problems. The counselor uses the knowledge gained and the understanding of the client's special situation to help the client interpret and clarify problems and to explore ways to lessen or resolve the problems. In establishing a therapeutic relationship, the counselor constantly provides support and understanding, helping the client through crises and difficult periods. The counselor uses a variety of techniques, including reality testing and direct feedback--constantly challenging, interpreting, and clarifying to help the client assess her unique situation and/or problem, the alternative courses of action available, the risks involved, and the possible consequences or benefits to be derived.

The counselor must also provide crisis intervention with the client and members of her family. Family involvement may be important, whether it is designed to enlist the support of the family in the treatment effort, to resolve a specific crisis, or to help the family restructure various roles and expectations.

The counselor should take an active role when working with the client and not simply listen or reflect back the client's statements. The relationship is based on acceptance of the client and a willingness to care about her, without taking responsibility for the client's decisions or actions. An atmosphere of trust, involvement, and communication is essential. The relationship will stimulate a variety of feelings in both the counselor and the client, but if the feelings evoked in either person are consistently negative or mistrustful, the relationship is unlikely to be productive.

> Joann, a 44-year-old woman, entered treatment distraught over her 18-year-old daughter's involvement with drugs and prostitution. The counselor found out, through questioning, that the daughter had been raised by Joann's mother until she was 13. According to Joann, the daughter was living on the streets and shooting Ritalin. She had been in trouble almost constantly for the past 6 years. Joann's mother had returned her daughter to her after the daughter's delinquent behavior had come to the attention of the school authorities.
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> The counselor helped Joann express her sense of guilt and her anguish about her daughter's circumstances. She also explored whether Joann was being realistic about her responsibility for her daughter. She pointed out that the same woman who raised Joann (who turned to drugs and prostitution) raised her daughter. Joann's only involvement in the process was a role model, which apparently her daughter was imitating. Joann's reaction to this idea was to focus on the guilt she had always felt about giving her daughter to her mother to raise. She got in touch with the pain she had felt in the separation from her child and realized that there was nothing she could do now to alter the past or even to help her daughter. The counselor helped her to begin mourning her daughter as a lost child, a process which was to last several months.

INTEGRATING THE ROLES--A DELICATE BALANCE

The five roles just described, in combination with one another, suggest the range of functions counselors will need to work with chemically dependent women. Each role responds to some aspect of the client's needs. The advantage of this multiple-role approach is that the counselor can move consciously from role to role, depending on the situation presented by the client, yet have a clear, consistent approach. For example, when the counselor acts primarily as a treatment coordinator and limit setter, s/he may evoke many negative feelings in the client. In turn, the client may resist the counselor, who is perceived as an authority. When the same counselor acts as the client's advocate, however, much of the client's mistrust can be neutralized, making it possible for the counselor to be more of a therapist and less of a limit setter.

THE COUNSELING PROCESS

> Each person constitutes a new adventure in understanding. Each is destined to broaden our own lives in directions as yet uncharted. Each interview renews our appreciation of the challenge and the fascination of the counseling task. (Tyler 1969)

This section will show how the 5 roles described above work in actual treatment situations with women. To do this, we will discuss each phase of treatment, from intake to discharge, using case examples. The cases will illustrate many typical problems of women in treatment and demonstrate techniques that the counselor can use or modify in similar situations. We will also discuss some of the risks and difficulties facing the counselor and show how the treatment process differs with different women.

The following presentation is not intended as a formula to be followed cookbook style by the counselor. No guidelines can possibly cover every conceivable situation; furthermore, each case is unique and will require individualized responses. The case examples and counseling techniques are intended to illustrate the multiple-role model in practice.

INTAKE

Most drug treatment programs have an internal intake procedure through which they screen potential clients, determine the degree and type of chemical dependency involved, and obtain preliminary information about the client. The intake process should also communicate basic information to the client about what she can expect from the treatment process, what the program expects of the client, and when a decision will be made on admitting the client to the program.

The intake process need not be a comprehensive assessment of the client's needs, strengths, and potentials. Often, insufficient time is available at the point of intake to realistically evaluate the client except in terms of meeting intake criteria. Nevertheless, intake represents the beginning of treatment. The manner in which the intake process is handled creates lasting impressions in the client's mind and will influence the interactions between client and program that follow. Applicants, even those who are not admitted into the program, will have an opinion about the way in which they were treated. They will talk about the program with others and will either seek out the program or avoid it (and others) later on, based on their experiences. A detailed description of what is involved in the intake process is presented in chapter 3, this volume.

The intake process is completed when the client is admitted to the program assigned to a counselor. After the intake worker has gathered all information and the necessary testing is completed, program staff can decide whether to admit the applicant and which counselor should work with her. The background information may indicate that she has pressing problems requiring a counselor with strong advocacy skills. Or, the intake worker may sense that it will be difficult to engage a particular woman, and the selection of counselor may depend on who has the time and willingness to become involved in a sustained outreach effort.

ASSESSMENT

When the client enters the program, the counselor faces the complex tasks of learning enough about the woman and her needs to design a treatment plan; beginning a counseling relationship; and responding to her immediate needs. This is the assessment phase of treatment, when both the client and the counselor are trying to find out if the program can help.

The counselor should explain the program and the treatment process to the client. Based on available information about the client's recent drug use (medical exam, urinalysis, self-report, etc.), the counselor must immediately assess the likelihood of withdrawal and the need for detoxification services. In methadone programs, counselors must determine whether the woman meets the criteria for being admitted to the chemotherapy program, whether the program offers the most appropriate treatment service for this client, and whether there are factors to be considered before making a decision to admit her. Does she have dependent children? Can she come to the program regularly? Does she take birth control pills? Does she have a tendency to use other drugs, including alcohol? Obviously, the decision to admit her into a methadone maintenance program must be made in consultation with a physician.

The client will have many questions and problems related directly to her efforts to abstain from drugs. At the same time, the program will be intervening dramatically in her daily routine and making new demands on her time and resources. The counselor should use a combination of techniques to guide her toward participation in the treatment process, including ongoing clarification of issues and concerns, assistance, advice, and reassurance.

Responding to Immediate Needs. The counselor must be prepared to respond quickly to the client's most pressing problems. For example, does the woman have transportation to the treatment program? Is she physically ill? Is she facing eviction? Some problems cannot be solved in a short time, and this fact must be explained to the client with assurance that they will work together to resolve these problems as soon as possible. Usually, the woman will express worries that can be addressed immediately, such as arranging for another client to give her a ride for the first week or locating a medical clinic where she can be seen without an appointment. The counselor should carefully choose one or two issues that can be resolved within a week or two. The counselor's immediate interest and demonstrated ability to help will offer hope to the client that her involvement in the program will be beneficial. If possible, the first problem to be tackled should support the client in dealing with a problem she has been attempting to address and should not disrupt or threaten any existing sources of support in the woman's life. For example, by helping a woman find a temporary source of income or transportation, she may become more prepared and willing to invest in the treatment process.

Gathering In-Depth Information. In the beginning of the process, the counselor should gather as much information as possible. The completed intake forms and medical records should be reviewed. Some of the needed information will come from observations of the client in interactions with staff, other clients, and her children. All staff members should be observing the client and her reactions to various situations, and the counselor should be informed of any incidents that occur during initial program activities. For example, a client may be threatened by a former pimp whom she meets while waiting in line for her dose. Her counselor will need to act swiftly to keep her from withdrawing from treatment. The counselor should also use early sessions to learn more about the client's past, her fears, her perceptions of others, and her support system. Her customary ways of coping with stress and taking advantage of opportunities, her plans for the future, and her past successes should all be explored during the first 2 to 4 weeks of treatment.

The counselor should be able to develop a clearer picture of the client as a unique individual with a history, a family, strengths and weaknesses, needs, and dreams. S/he should learn when and how her client first experimented with drugs; when she became addicted; when she felt and functioned best; what role she played in her family; and what kind of family she came from.

Although much of what the client reports about herself and her situation will be tailored to what she thinks the counselor wants to hear, the counselor can learn a great deal about her self-image, her coping skills, and her problems through a careful exploration of her history and present situation.

The counselor must attend to confidentiality issues early, making sure that the client understands who will have access to the information she gives. Program regulations usually specify a procedure to be followed in releasing information to persons not involved in the program as staff. If records are subpenaed, they must be provided in accordance with the law, but only to the extent that they are directly required by the subpena. Otherwise, an authorization for the release of information must be signed by the client before any information can be provided. In the case of a referral, the client should be aware of what information is requested by the other agency and should decide whether she wants her counselor to provide this information. She then signs a release.

It is another question when the need for information comes from within the staff of the program. We recommend complete sharing of information among clinical staff. First, to develop a unified treatment approach, the staff members must have access to the same information. For example, the nurse may need background information to know what to look for and what information to provide the counselor in return. The client may attempt to manipulate various staff members if she senses that there is no unified approach or sharing of information.

Therefore, the counselor should explain to the client early in the intake or assessment process that clinical staff members share information about clients so they can work together as a team but that the staff will keep all information confidential and not share it with anyone outside the staff without the client's written permission. The counselor can thus obtain the support of other staff members without betraying the client. This approach will also enable the counselor to use the combined resources of the staff in diagnosing the client's status, problems, progress, and the development or modification of treatment plans. If the counselor is ill or unavailable, other staff members can work with the client. If the counselor is reassigned or leaves the program, his or her clients can readily turn to other staff members without having to start over.

Gathering Case Information. Information for an initial assessment usually comes from a variety of sources:

- Client self-reports,
- Structured interview formats,
- Staff case conference notes,
- Other agency reports (parole, caseworker, etc.), and
- Urine screens.

Our experience has shown that a detailed assessment profile is useful in treatment planning. The profile should consist of the following elements.

- Demographics and Basic Information. Collect information on the client's age, sex, date of birth, race, social security number, marital status, number of children, ages of children, children's residence.

- Education. Obtain information on the client's formal and informal schooling--types of degrees or credentials, highest grade completed, and perceptions of the importance of more education or training. If she plans to enroll in a program, ask her about the training area and the type of degree or certificate she can obtain.

- Employment. Ask about current and past jobs. Obtain the names of employers or organizations and the length of employment at specific jobs. Determine how she found out about the job currently held and how well she gets along with her supervisor and coworkers. Ask about problems at current or past jobs. When applicable, ask why she left previous jobs. Was the reason drug related? Did the employer know about the client's drug history, and if so did this cause problems for the client? Ask if she makes enough money from her current job to support herself, and inquire about her perceptions for supporting herself in the future. Ask if she has received vocational counseling, and question her about her vocational aspirations.

- Medical History. Ask about her health status, the history of her medical treatment, any illnesses requiring hospitalization, any illnesses causing her disabilities, preventive health habits (e.g., diet, smoking, sleep patterns), history of dental treatment, source of insurance, and the person who takes care of her when she is sick. Also, note drugs the client takes when she is sick.

- Living Arrangements. Collect information on where the client lives, the type of dwelling, how she found out about it, members living in the household, their ages and relationship to the client, how much rent she pays per month, any problems she has in her living arrangements, who could house her on a short-term basis, and her perceptions of the neighborhood.

- Legal Status. Obtain a detailed profile of the client's criminal history, current parole or probation status, current legal problems, the person she goes to for help, the person she talks to about legal problems, and if pending charges interfere with any plans for jobs or education.

- Income. Other than a regular job, probe for additional sources of income. Determine if money is obtained from legal or illegal sources (i.e., prostitution, dealing, other "hustles"). Ask if she has credit cards in her name. Ask about living expenses, monthly income, the ways she usually spends extra money, and specific money problems she feels she has.

- Leisure Activities. Question the client about recreational activities or hobbies she pursues. Does she wish to join any clubs or groups in the future, and if so, which ones? With whom does she spend her free time? Determine what she does with friends. Does she visit and talk, take drugs, etc.? Determine what activities she especially enjoys and find out if she has the resources to pursue these interests.

- Transportation. Determine what type of transportation the client has at her disposal. How does she get around? Is it reliable? Does she have problems getting to the treatment program or other agencies? Does she have a valid driver's license? Is public transportation accessible to her?

- Social Supports: Friends and Contacts. Determine whom the client goes to for emotional support, information, or services. With whom does the client exchange services? Is there someone who can babysit for her children or take care of her house if she is gone? Who are her friends? Are they anchored to the drug or the nondrug world? How difficult is it for the client to make friends who aren't in the drug scene? Does she go to anyone for advice about personal matters? Whose opinion does she consider about important decisions? Whom can she depend on in an emergency? What are the positive aspects of the network that facilitate reentry? What are the negative aspects of the network that hinder reentry?

- Family History. Obtain a detailed family history on the client. Inquire how many siblings she has and their birth order. Ask her about her home atmosphere and how family members get along.

- Drug and Alcohol Use. Question the client about her current use of opiates and other drugs. Is she using drugs occasionally or actively? What does her drug habit cost per day? Does she use drugs alone or with other people?

- Motivation for Treatment and Requests for Services. Determine why the client came to treatment. Was her entry voluntary, or was it due to outside pressures, such as a court mandate? Was she having medical or legal problems? Did she experience social pressures from family or friends? Is her drug source still available?

  What goals has she set for herself now that she is in treatment? Can she distinguish between short-term, interim, and long-term goals? What are her expectations of the counseling relationship? Ask her about what problems the counselor is likely to cause, or what worries she has about having a counselor.

Psychosocial Assessment and Clinical Impressions. Ask the client to identify her strengths and weaknesses. What things is she good at? How effective is she in solving day-to-day problems? Has she established long-term goals? How does she go about organizing things in her life? Does she follow through on goals? How does she respond to stress or change? What are her perceptions of her emotional health? Does she feel lonely or depressed? Does she verbalize feelings of boredom? What are her pleasures? What makes her feel good about herself? How important is it for her to get help with personal problems? To whom would she go for help--a friend, relatives, or professionals? How comfortable does she feel when talking to professionals about her problems?

Record your clinical impressions of the above information. What is your assessment of the client's strengths and weaknesses? Are there similarities between your assessment and the client's assessment?

DEVELOPING THE TREATMENT PLAN

Approximately 2 to 4 weeks after the client is admitted to the program, the assessment phase should end in the creation of a treatment plan. This plan helps the counselor and the client focus on short- and long-term treatment objectives. It establishes some mutual expectations on what help can be expected and what changes can be anticipated over time. It is a written "contract" between the counselor (who represents the program) and the client. It also spells out tasks involved in accomplishing desired goals and serves as a guide for specific activities.

Like a road map, the treatment plan can be checked for accuracy and compared with actual conditions facing the client and counselor at any time. When the plan is inadequate, or when new problems arise, the plan can and should be changed. Considerable care and thought should be taken in developing the plan. The success or failure of the treatment effort should be measurable in terms of the goals outlined in the plan. Whether the client, the counselor, or the program is attempting to gage the effectiveness of treatment, the plan can serve as a useful yardstick. In addition, the plan helps the client and counselor identify potential disagreements and conflicts regarding what they can expect from one another. As such, it can serve as an extremely valuable means of communication. When the client agrees to a specific plan, she is more likely to make a stronger commitment to the treatment process and increase her chances of fulfilling her goals.

In developing a treatment plan it is important to identify the basic needs of clients. Clients themselves are the best source of information. Since our experience has shown that during the early stages of treatment, many clients have difficulty expressing needs and desires, we recommend the following strategy to facilitate this process.

Board Game. Ask the client to visualize her needs by giving her 55 tokens, which will be placed on a board listing 10 problem areas in addition to drug use (figure 1). Ask the client to distribute the tokens as she sees fit, given her current needs for treatment. For example, Mary distributed 35 tokens on the housing slot because she faced eviction and was desperate to find suitable housing for herself and four children. Jane distributed most of the tokens on the drug use slot because she viewed her personal drug use and involvement in the addict lifestyle as her most pressing and immediate

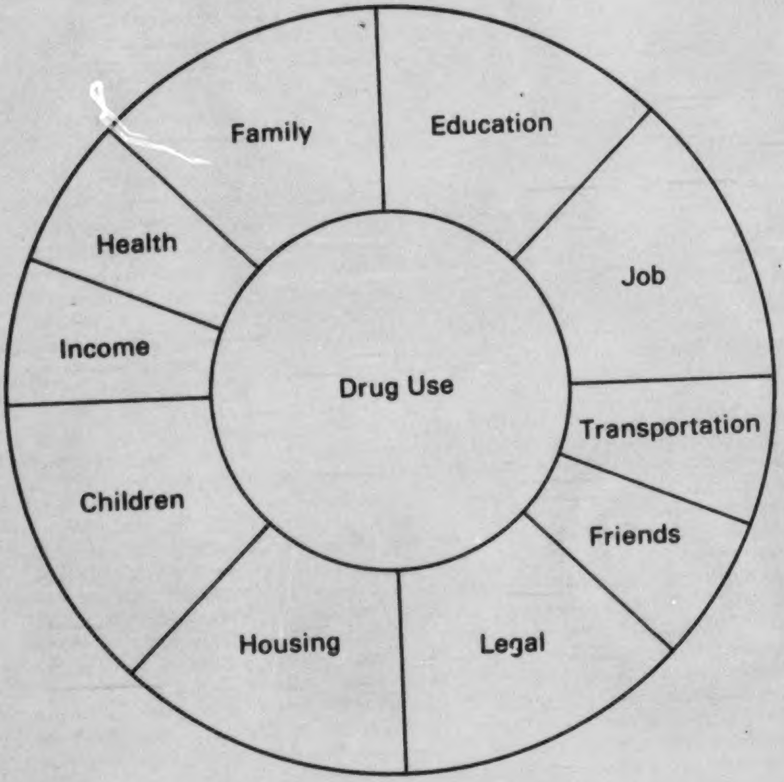
Family
Education
Health
Job
Income
Drug Use
Transportation
Children
Friends
Housing
Legal

FIGURE 1. Drug use board game

problem. If a client has difficulty identifying her problems, the counselor should still try to set her at ease by letting her know that they will share ideas to help define needs or expectations. Some clients may feel too ashamed to express problems openly. This board game helps most clients express and rank their problems. With this information, both counselor and client can proceed more quickly to resolve problems. Furthermore, if a client senses that immediate help is forthcoming, she will be more motivated to participate actively in the counseling process. The first few sessions are critical and will probably determine whether the woman remains in treatment.

Staff Coordination. To be effective, the treatment program should function as a coordinated unit with all clients. The counselor generally plays the key role in this process, organizing, facilitating, and managing case conferences. The case conference can be an effective counseling tool if it is well organized. It can be structured to involve several staff members who have ongoing contacts with a particular client. An agenda and appropriate material are prepared and given to the staff (team) prior to the case conference. If possible, case conferences should be scheduled regularly so that they become part of the staff's regular routine. Conferences can be arranged prior to the preparation of formal treatment plans, periodically during the course of treatment, and when emergencies or special problems develop.

One format for developing the initial treatment plan is to schedule a case conference to summarize and analyze information about needs and problems. A preliminary plan is discussed by the staff participants, with the counselor taking notes. The counselor constructs a preliminary plan based on the notes and reviews it with the client. The client accepts, rejects, or suggests alternatives to the goals or tasks spelled out in the plan. The counselor then prepares the final plan for the client's file.

In another format, the client (with counselor assistance or in collaboration) draws up her own treatment plan, which is then reviewed by other staff members (and perhaps other clients). With questions, suggestions, and even challenges to the plan, a realistic composite plan evolves that the client, counselor, other staff, and other clients understand and support. The client can also gain self-confidence, self-analysis, problem-solving, and interpersonal skills in this process if the setting allows for an open exchange with support and assistance available to her.

Jane's Treatment Plan. The following is an example of the process used to develop a treatment plan. We show how the plan develops from the information presented at the case conference and how the client handles the suggestions of the staff. Her acceptance of the final plan is the last step in the process.

After Jane had been in a methadone maintenance program for 3 weeks, her counselor presented the following information to the staff at a case conference.

Psycho-Social Profile

Jane is a 24-year-old woman with no children. She is entering treatment at this time because her husband Robert, aged 53, was assigned to the program 6 weeks ago as a condition of parole. She reported that although her husband was putting some pressure on her, she also was tired of prostituting to buy heroin and was fearful of getting arrested while buying drugs.

At the time of intake, Jane complained about her living situation. She lives in a studio apartment with her husband, and feels that the neighborhood is unsafe. She is concerned about the roaches and has problems with the neighbors, especially men who harass her when Robert is not at home. In spite of these problems, she has no plans to move because she can't afford a better place.

Jane completed the ninth grade and has had no job training. Since the age of 16, she has supported herself through prostitution. She seems to have mixed feelings about her source of income. She is proud that she works in a massage parlor rather than on the streets. She also says that Robert depends on her to support them both, and does not have other alternatives. She is not in a position at present to obtain a straight job. She expresses shame about her work, and feels that other people can sense that she's a prostitute. She avoids people as much as possible, and is often depressed about the life she leads. She reports that she takes heroin mostly to cope with her sense of worthlessness and shame. She spent several nights in jail for soliciting but was always bailed out by her husband. When he went to prison for dealing, she found a massage parlor that employed several addicts and secured another connection for drugs from one of the other women. Jane spent a good deal of her adolescence in juvenile hall and foster homes and is fearful of arrest.

At this point, Jane's health is good, according to the results of her physical exam. She has dental problems that need attention and has an iron deficiency. She has no medical insurance. However, Jane found a gynecologist, whom she sees every month. She has had V.D. and also two abortions in the last year and a half. She feels that it is important to see the gynecologist regularly.

Jane's relationship with her husband has come up often in our initial sessions. She believes that he saved her life because at the time they met she was contemplating suicide. They have been together for the past 5 years, except for two periods when Robert spent time in prison. Jane reports that they fight frequently, especially about Robert's relationships with other women, but she would never leave him "because he is her whole life." She did manage rather well when he was in prison, but her emotional dependency is intense. In addition, she is dependent on him for transportation. She doesn't drive, and when Robert was in jail she gave his car to a male friend on the condition that he take her back and forth to work and to other appointments. Now that Robert is at home, she goes nowhere without him. Jane's role in the household is to make money, take care of the house and bills, and wait for Robert to come home when he goes out without her.

Historical Information

Jane was adopted at birth by working-class parents in their early forties. The family had one other child, a boy 4 years older. They told Jane that the doctor had advised them not to have any more children because of their age, and they had decided to adopt a girl.

Jane was raised in a very religious, rigid atmosphere. Her father was authoritarian, and her mother rarely disagreed with him about anything. Jane describes them as "very good, very holy people, who never got angry, never raised their voices, and always did the best they could." When the children quarreled, the parents were horrified. They told her that their son did not behave so shamefully until she came, and that she must stop provoking him to the sin of anger. Bible quotations were used extensively in handling behavior and she was often sent to pray for God's forgiveness. Jane resented her brother's favored position but felt guilty about these feelings. She thought she should be grateful to her family for taking her in, but she didn't believe that they really loved her.

Jane internalized the religious values of her family. She worked hard to please her parents. She also did very well in school, relating much better to her teachers than to her peers. She was shy with other children, and often fell victim to teasing and bullying, which she never learned how to handle. Jane became a quiet, almost secretive child, hiding most negative feelings behind a compliant facade.

At puberty, Jane experienced two traumatic events that were to alter radically her perception of herself and her functioning. At age 9, she spent the summer with an aunt and uncle. On several occasions the uncle fondled her in a sexual way. She was troubled, confused, ashamed, and strangely excited. She didn't tell anyone about this experience, but felt burdened by guilt and fearful that her uncle would expose her to her parents as a bad girl. When she was 12, her brother took her into the garage where two of his friends were undressed. They cajoled and coerced her into stripping, then raped her. This time she told her mother, who smacked her and told her to stop making up lies. She avoided her brother, but she was deeply disturbed about her mother's reaction. She was angry and yet couldn't accept the idea that her mother would let her brother treat her in such a horrible way.

Over the next 2 years, Jane withdrew more and more. She daydreamed at school, and as her grades dropped, she pretended sickness to stay at home as much as possible. Later, she began to cut school and go downtown to window-shop. Eventually, she began shoplifting but was caught and taken home by the police. Her family reacted with rage. This was the beginning of a period in which Jane expressed her own anger and sense of worthlessness through delinquent activities. By the age of 15, she had been suspended from school for truancy and was regularly meeting boys much older than herself at the local park. They introduced her to marijuana, then began using her as a runner to customers. She was caught while delivering a supply of marijuana. When her parents were notified, they refused to take her home. She served a 6-month sentence in juvenile hall. Upon release she was placed in a series of foster homes. She continuously ran away, going back to her friends on the streets. At 16, Jane started prostituting. She lived with a pimp who supplied her with drugs. During this period she was dependent on alcohol, marijuana, and various tranquilizers and sleeping pills. She left town and lived with a succession of men. She tried heroin, and in a short time became addicted.

At 19, Jane had disintegrated to the point of contemplating suicide by taking an overdose of heroin. After she attempted this twice, her pimp threw her out and she met Robert, who decided to take her in. Although Robert was also addicted, he and Jane developed a strong relationship, and the combination of a steady source of supply of heroin and Jane's feeling of belonging to Robert has stopped her from feeling suicidal for the past 5 years.

Analyzing the Information. The staff discussed Jane's case for 2 hours. Their first task was to add other pieces of information, especially observations by the other counselors and the nursing staff, and to check on the client's urine testing record to see how well she was handling her withdrawal from heroine. The testing report was quite favorable; Jane had had only one "dirty" test in the first week. The following weeks were marked by good attendance at the program, including group and counseling appointments as well as picking up her methadone. The counselor leading the intake group for new clients reported that Jane was extremely quiet and noncommittal, even when directly addressed by other clients or the leader. All staff noted that she appeared to be cooperative, even docile. She was not offering much information about herself, but she was also not testing the program's regulations or attempting to manipulate the staff to obtain special favors. The counselor working with her husband, Robert, was pleased that Jane had entered the program and was progressing so well. She had some doubts about Robert's commitment to treatment, and felt that Jane's participation would influence Robert's participation. The question of family therapy came up immediately because Robert's counselor wanted to take advantage of the couple's presence in the program to assess their relationship. Jane's counselor resisted this idea as too threatening at this stage, but agreed that if the session were scheduled in 2 weeks, and if the agenda were structured around limited issues, it might be useful to see the couple together.

This issue was the first of many to be decided in the treatment planning process. At the initial conference, the staff organized the information into a psychosocial diagnostic format. It included information related to the client's requests for services, current strengths, social supports, areas of environmental stress, initial response to treatment, predicted areas of resistance, personality type, coping mechanisms, interpersonal problems, vocational issues, marital issues, areas of psychological conflict, level of psychosocial maturity, and other special problems. The case conference and diagnostic information helped produce a portrait of the client that made it possible to develop a treatment plan.

Client's Requests for Services. Jane had talked about needing many kinds of services during the first five sessions of the assessment period. She wanted to be on methadone maintenance. Jane also hesitantly asked about finding an alternate income to help her stop prostituting, getting help with her shyness and lack of friends, possibly obtaining her high school diploma and eventually a job, and learning to drive. She knew she needed to see a dentist but didn't place as much importance on this as on the other issues. The counselor felt uncertain about what to focus on. In the case conference the staff made a psychosocial assessment of Jane's strengths and weaknesses, which helped identify which goals could be accomplished in a relatively short time and which issues would probably be more difficult to resolve.

Psychological Assessment. The staff perceived Jane as having functioned well, with some social shyness, until the traumatic events of early adolescence. Her early childhood family conflicts may account for her reliance on Robert. Jane's low self-esteem was related to many of her early experiences. She did not feel fully accepted into her adopted family. She had experienced feelings of guilt as a result of the incidents with her uncle and brother. She had no acceptable outlets for handling her reactions to these events and situations in which she was victimized. Feeling isolated and alone and without any means of gaining support, she became depressed and self-destructive. She used heroin and other drugs to cope with the feelings of anger and depression. Her current life circumstances and lack of perceived alternatives perpetuated these feelings.

Jane's marriage provided some stability and self-esteem. It was felt that so long as her marriage remained stable, Jane would pursue rehabilitation goals. If the marriage deteriorated, her situation might become much more difficult. Some staff thought that Jane might, at some point, need antidepressant medication or psychiatric counseling.

Client Strengths. In response to questions on her strengths, Jane described herself as a good listener and a kind, honest person. She was proud of the fact that she did not steal to maintain her habit, and she felt she was a good budgeter and planner. She handled the bills and food budget carefully and believed that she could make sacrifices when necessary to achieve a goal. Although Jane presented herself as a "little girl" in a way that invited others to victimize her, she could also use that image to obtain approval and cooperation from others. These strengths helped her to cope with the demands of the treatment program, and the staff anticipated that she would continue to participate so long as the program did not make demands beyond her level of functioning.

The Treatment Plan--Selecting Short-Term Goals. With these points in mind, the following short-term goals were formulated. Short term, in this case, meant that the goals could be accomplished within a brief period, usually less than a month, and would require no major new skills from the client.

1. Make a plan with Jane for obtaining general assistance at the county welfare program for unemployed adults. Provide Jane with information on the level of benefits; the process for obtaining them, including the needed documents and procedures; and the time involved. Spell out the exact help she can expect from the program, including help in filling out forms and followup phone calls from the counselor to guarantee prompt processing.

2. Help Jane plan a budget using only welfare income. Discuss how this change in income will affect the marriage, and have Jane consider whether she would appreciate having a meeting that included her husband and his counselor to discuss finances and other factors involved in their participation in treatment.

3. Move Jane from the intake group to a women's group. Since the women's group has a policy of pairing new members with more experienced ones, it can help Jane develop some relationships immediately that will help her feel less isolated when she stops going to the massage parlor. The chapter entitled "Women's Groups as a Form of Intervention for Chemically Dependent Women" in volume 2 describes more fully the benefits and activities possible in all-women groups.

4. Encourage Jane to use and recognize existing strengths in accomplishing goals 1 through 3.

These short-term goals were chosen because they would be reasonably easy to achieve and would give Jane a sense that the counseling relationship would be useful and would resolve some of her immediate problems.

Selecting Intermediate Goals. The staff looked at Jane's other problems and potentials and recommended intermediate goals and tasks. These were termed intermediate because it was unclear how long they would take to accomplish; it was believed they would not require more than 6 months. The focus of intermediate tasks and goals is to build on the short-term gains and to prepare for work on long-term goals. Intermediate goals were as follows.

1. Help Jane obtain secure income from legitimate source.
2. Help her reduce feelings of depression and anxiety.
3. Increase her health maintenance skills and awareness.
4. Begin assessing vocational potentials, interests, and awareness. Increase her self-esteem in this area.
5. Move toward obtaining a high school diploma or passing an equivalency test.
6. Develop at least one friendship that allows her spontaneous expression of feelings.
7. Increase Jane's self-esteem in all areas.

The following tasks were designed with these goals in mind.

1. Provide advocacy in income area. Insure maximum cooperation from department of social services through telephone followup.
2. Provide supportive counseling, teach Jane relaxation techniques, identify sources of low self-esteem, depression.
3. Help her secure medicaid card through social services department. Refer Jane to dentist and followup. Refer Jane to health classes given at the program, including nutrition, contraception, and health maintenance.
4. Locate adult education program in Jane's area. Arrange for vocational rehabilitation staff to give Jane vocational tests. Arrange for women's group to visit career guidance center at local community college. Work individually with Jane on vocational identity issues.
5. Arrange for Jane to be tested at the adult school and enroll her in a high school equivalency class. Provide support in group and individual sessions to handle anxiety related to this task.

6. Use women's group through close coordination with group leader. Structure group activities so that Jane gradually takes more risks in expressing feelings. Use individual sessions at times to discuss Jane's feelings about women met in the program and her activities with them. Assign Jane to make and keep one social engagement per week with another woman in the program or at class.

7. Review Jane's progress with her at least every 2 weeks. At the end of each goal accomplished, highlight her progress in individual sessions. Go over each step Jane took that contributed to the success of the plan. Ask Jane to help another client as soon as possible, and bring to her attention how she was able to be of service to someone else. Praise her periodically for abstaining from drug use. Do everything possible to insure that Jane is reinforced by group and by other program staff and clients.

Selecting Long-Term Goals. Long-term goals are generally easy for the counselor to envision but difficult for the client to accept. In fact, many of these goals may not be achieved during treatment. Their realization requires a major commitment of resources by the program, an equally large commitment by the client, a long process of gradual change, therapeutic work on behavior changes desired, mastering major new skills, cooperation from one or several community or social resources, and sometimes all of the above. Many long-term goals are not requested by the client at all but are envisioned by the staff as necessary to the total rehabilitative process. If the client does recognize her need for accomplishing the goal, she is also likely to seriously underestimate the difficulties involved in reaching it. She may become so discouraged by the intervening setbacks that she gives up altogether. In outlining the following long-term goals, the staff was unsure how Jane would feel about them, but saw them as needed in the long run for her successful functioning as an independent adult.

1. Jane works through sexual guilt, becomes more comfortable with her sexuality.

2. Jane chooses a vocational goal, secures financial assistance, and completes training to prepare for career.

3. Jane develops social skills sufficient to make friends at school, handles classroom situations comfortably.

4. Jane becomes more assertive both with authority figures and with strangers.

5. Jane obtains driver's license and ends dependence on husband for transportation.

6. Jane reevaluates her family of origin, develops insight into their contribution to her strengths and difficulties. She differentiates herself and her values from those of

her parents, decides what kind of relationship, if any, she wants to have with them, and finds the one that is most comfortable.

7. Jane develops a similar sense of perspective on her marriage. She recognizes the positive and negative aspects of the relationship and works to improve it.

8. Jane takes steps to become drug free.

The long-term tasks were as follows.

1. Encourage Jane to talk about her early experiences with her uncle and brother in the context of her feelings about herself and prostitution. Help Jane recognize her victimization and begin to express her anger. Use women's group for exploration of sexuality, both therapeutic and instructional. As soon as she is willing, have Jane read some books on sexuality. Allow Jane to talk about sexuality in her marriage and her degree of satisfaction.

2. Get report of vocational assessment done by vocational rehabilitation specialist. Do additional assessment in counseling sessions. Have client explore interests, eventual financial goals, and needs. If she is interested, help her locate volunteer jobs in areas of interest or find entry-level opportunities. Teach her how to conduct an exploratory interview with someone who has a job she is interested in. Devote one session in three to educational and vocational issues until Jane makes a decision. Then, arrange for her to obtain financial assistance and admission to a training program.

3. Use women's group to work with Jane on her preconceptions about the reactions of others to her. Encourage her to express her own reactions and opinions of other people. Develop a desensitization plan for handling anxiety in social situations. When ready, give assignments for entering new social settings with graduated degrees of significance.

4. Use women's group for assertiveness training; solicit Jane's reactions to training in individual sessions.

5. Help Jane enroll in driver's education at the adult school. Work on her problems in the driving process in individual or group sessions. When she is ready, encourage her to borrow her husband's or a friend's car and take the driver's test. Arrange a party of celebration when she passes.

6. Use individual sessions to look at historical material whenever Jane brings it up. Interpret her family's actions as those of people with their own limits doing the best they knew how. Compare what she has learned in the program

about how people function and grow with the message she got from her family. If she decides to make contact with them, encourage her to do so, but ask her to think about what her purpose is before each contact, and to come back and talk about what she learned afterwards.

7. Let Jane take responsibility for bringing up problems with her marriage. As she feels better about herself, she will be more bothered about her husband's behavior and attitudes unless they change. Help her analyze what she gets from the marriage, and discourage her from separating from him impulsively or moralizing about her need for him. If separation occurs, do crisis intervention and maximize social supports. Evaluate need for medication. Increase counseling sessions to stabilize.

8. Prepare Jane to leave the methadone program gradually, starting with some dosage reduction at a time when Jane's life is relatively stable and she is feeling highly committed to the program. Raise the issue of termination at least once a month, especially in connection with her involvement with people at the adult school and the college or training program.

Jane's Response. Jane was amazed at the detail of the plan. She thought that the goal of treatment would be for her to stop using heroin and had not realized that the staff would want to help her to solve so many problems or see their relationship to her drug use. Her reaction to the short-term plan, including goals and tasks, was generally positive except for the section on her husband's reaction to her stopping prostituting. She feared that he would not allow her to stop because her income from welfare sources would be minimal, and the welfare department would exert pressure on her husband to obtain employment and otherwise interfere in their lives. She did feel that continuing to prostitute would be very difficult if she did not take drugs, but she didn't see how her husband could be persuaded to agree to the plan. She agreed to having a couple's meeting to discuss the issue.

Jane had mixed reactions to the intermediate goals and tasks. She noted that the goals referred to changes Jane would make, rather than changes the program or counselor would make. Tasks were in reference to the activities of the counselor to help Jane achieve goals. The counselor explained that she would take responsibility for doing the tasks, but that Jane must take responsibility for cooperating with the counselor because she wanted Jane to achieve the goals for herself. The counselor questioned Jane's feelings about each goal. Jane wondered whether she could find a job to provide temporary income, and it was suggested that this be added to the intermediate goals list after initial goals were achieved, if the welfare problem created difficulties in the marriage. The counselor and Jane talked about the amount of time and energy that would have to be devoted to the treatment process, especially at first. Jane agreed that they couldn't make a decision about the job until she had adjusted to the treatment routine and tried living without her prostitution income. Jane quickly agreed that her health was an important issue, and would see the dentist as soon as she had a medicaid card. She was hesitant about whether she could go back to school and worried about the other students at the adult school. The counselor suggested that when the time came she could accompany another client who attended the adult school's high school equivalency class. Jane also expressed doubts about the possibility of developing a friendship with anyone within the next 6 months. The counselor told her that if she didn't achieve a goal in the 6-month time, it could be added to the long-term list without being considered a failure.

Jane expressed the most doubts about the long-term goals. She disagreed with the phrase "sexual guilt." She thought she was just embarrassed about her work as a prostitute and had no feelings about anything that had happened in her childhood. The counselor assured Jane that she wouldn't force her to talk about sexual matters until she brought them up, and in fact, after most of the intermediate goals were accomplished, they would look at the long-term goals again. At that time new goals could be added, and any goals that Jane thought irrelevant would be eliminated. On this conditional basis, Jane allowed the sexual goal to remain. She expressed enthusiasm about the picture painted by the long-term goal list. She said, "It doesn't even sound like me. It sounds like the heroine in a play or a big success story. It would be great if any of those things happen."

Jane wanted two additional goals, and she discussed them with her counselor to see where they fitted into the plan. One goal was to find a better place to live, and another was to buy her own car. It was clear that Jane would want to earn some money or find a resource to provide more money than was available from the welfare grant. The counselor suggested that when the intermediate work was done on vocational issues, she might want to work for a few months to earn additional money, or she might want to apply for financial aid and school loans sufficient to cover the cost of a car and a better apartment. These goals were added to the beginning of the long-term list, and the counselor agreed that they were worth pursuing.

Jane was pleased with her additions, but felt somewhat overwhelmed by the large number of changes they would be attempting to make in her life. The counselor worked with her on how these changes might be risky, and Jane immediately responded with worries about her husband's reaction. Jane and the counselor both agreed that the success of the marriage in the long run would depend on how much each of the partners was able to support the other in making changes. Jane signed the treatment plan, and so did her counselor.

After the Plan. When the client has agreed to the treatment plan, the long process of treatment begins in earnest. If the client can accept only the short-term goals, or if there is great disagreement with most of the goals, the counselor can be prepared for a brief treatment effort. No sustained attempt can be made to work toward goals that the client does not want to achieve. Therefore, the treatment plan spells out the basis for that relationship between the client and the counselor through the next phase of treatment.

ESTABLISHING THE COUNSELING RELATIONSHIP

During and after the development of the treatment plan, the counselor must establish a counseling relationship with the client. No matter what specific problems, needs, and goals the client has, she will need a relationship with the counselor based on clear communication of mutual expectations, support, reassurance, concern, limits, and continuity. This relationship usually takes considerable time to develop, but the foundation will be built upon the actions carried out by the counselor and by the client. These actions begin at the first contact. They are based on the guidelines in chapter 3, this volume, but they go further in working with the emotional needs of the client.

Setting the Ground Rules. The structure of the relationship must be made clear. First, the counselor explains her/his role in the overall treatment process. S/he tells the client how often they will be meeting and whether the client has a choice in the number, duration, or scheduling of appointments. Counselor availability outside the regular visits should be spelled out. The client should know how to contact her counselor in a crisis, and who would be available to see her if the counselor is ill or on vacation. Then, the counselor explains her/his functions and describes how s/he will try to help the client. The counselor should be explicit, using concrete examples, so that the client clearly understands the kinds of help the counselor can give. The client will be making decisions at all times on what information to give the counselor, and she will base these decisions, in part, on her understanding of the counselor's role.

It is also important for the counselor to explain how s/he interacts with other staff members. The counselor should be careful to delineate the extent of her/his authority in planning and carrying out treatment. Decisions about the client's continued participation in treatment, in the event of the client's failure to conform to program rules and expectations, may be, for instance, in the hands of the total staff. The counselor should also explain how s/he shares information about the client's needs and circumstances with other members of the treatment staff and coordinates the treatment process with the group leader and the nurse on a regular basis.

The next issue for the counselor is to clarify what choices the client is free to make in their relationship. The counselor can specify choices that the client can make, such as whether to discuss certain topics, and when she is ready to make certain changes. It is a good idea to specify that the client is free to express any feelings and thoughts she wishes, and that she is not expected to be pleasant and cooperative all of the time, or even most of the time. The counselor must begin to emphasize the difference between feelings or thoughts and actions. Although the program will place many restrictions on her actions, the client should know she will find acceptance for any feelings she expresses.

Other basic expectations should be clarified and discussed with the client, particularly the client's expectations of the counselor. In this way, some of the anxiety felt by the client in facing an unknown situation will be dissipated, and the beginnings of understanding and honesty will result.

Providing Reassurance and Instilling Hope. The client is likely to be apprehensive about the treatment process and pessimistic about its outcome. Therefore, the counselor's task is to provide as much reassurance as possible as to the treatment process and to give the client a sense of hope that her life can be substantially better as a result of her participation.

Usually, much of the client's apprehensions are based on the fact that she will be giving up the drugs and activities that have sustained her in the past, with little idea of how she will cope without them or what new supports she will have in the future. It is very important that the counselor not deny or minimize the realistic aspects of these fears. The counselor must acknowledge that the client can expect to feel lost and anxious at the beginning, and in fact will have a desire to go back to her habitual activities. The program does not expect her to give up a way of life overnight, and in fact it anticipates that she will be experiencing much turmoil in the first few months.

The counselor should then explain how the program will be available and actively providing support for the client. If the client is to get along without her former livelihood, she must have an alternate source of income as quickly as possible; the counselor can take an active role in helping the client with this problem. The client will also experience a sense of chaos as her former routine is disrupted. The counselor must explain how they will be structuring her time, making sure that she doesn't have too much time alone or without constructive activities. The client will miss her former companions and will have difficulty in pulling away from familiar people. The counselor should explain that one function of the women's group she will attend is to help her make contact with other women in the same position and to encourage the members of the group to give companionship and support to each other. The counselor should also remind the woman that she can talk to the counselor about these feelings as they come up.

The client's cravings for her usual drugs might also cause problems. If the client is taking methadone, the counselor should monitor the client's reactions and experiences and should tell the client what she can expect from this drug. The client may have great difficulty sleeping or may develop other symptoms of withdrawal even with the methadone. The counselor should be in constant communication with the program's physician to make sure that the client does not experience unnecessary suffering during this difficult time.

The client will have other experiences as she begins to live without chemical supports. As the drug effects wear off, she may find that she is much more anxious or depressed, that she suffers from extreme mood swings, shortness of temper, increased sexual desire, and increased fertility. If the client expects these reactions, she will handle them much better and will report them accurately to the counselor. Each problem can be handled and managed better if the client and counselor work on it together. The counselor should remind the client that some of her anxiety and depression is a result of the increased awareness she has about her circumstances and her feelings, which are no longer blocked by drugs. These feelings will lessen in time as she works out some of her problems and as she gains mastery over her need for drugs.

At this stage, it is important that the counselor gives the client a sense of hope for the future. Telling the client about others who have rebuilt their lives is helpful, but it is far more effective to introduce the client to other women who are further along in the treatment process. This can be best accomplished in a women's group. As each woman tells the newcomer her story, the client sees that other women have gotten through these painful first months and have made new choices and plans.

The counselor should also make a distinction between past negative actions and failures and future opportunities. The counselor should stress that the client is at a crossroads, and that it is possible to go in a new direction even if the client has never succeeded in doing so in the past. The issue of choice is most important because the woman must begin to imagine herself making changes that will lead her toward a more successful future. It is most important that the counselor remind the client that she is not expected to achieve these goals on her own but will be given much support and practical help by the counselor, by other staff members, by clients in the program, and by agencies and persons outside the program.

Countering Depression. As the client gives up her old way of life, she is likely to become depressed. The sources of this depression are complex, but two main sources must be dealt with directly.

First, the client will experience a sense of loss and is mourning that loss. The client must be encouraged to express her feelings as fully as possible so that the mourning process can take place in a natural way. At first the client may deny that she misses using drugs or anything else about her former life, but soon she will begin to recount some of her positive experiences while dependent on drugs. She should be encouraged to tell her counselor about these good times in the past and should be told that this is part of the process of saying goodbye. She may fear that by participating in the rehabilitation program she is endangering other aspects of her life, including her relationships. The counselor should agree that changes may occur, and that these changes are difficult to predict.

The counselor should discuss the risks involved in making these changes. When possible, the counselor should discourage the client from dire predictions about the reactions of others and encourage her to take things as they come. The counselor should remind the client that it is impossible to predict how other people will act, and that there is always the possibility that others will act differently when they see her acting differently. In any case, the client will be stronger and more able to cope with the future.

Another source of depression is the loss of identity the client experiences as she becomes an ex-addict. She may have a great deal of shame and guilt about her former lifestyle, but she at least knew who and what she was. As she attempts to change, she will not have an identity to cling to at first. The counselor can explain that this change involves letting go of a part of herself and that a healing process must occur before she will be ready to go forward and adopt a new identity.

In addition to the recognition and reassurance that these discussions will give, the client will need concrete support. This is a good time to arrange for another client to help out with transportation or simply to offer to accompany the client on an errand or a shopping trip. The client should make plans for company and activities over the weekend, and may need an occasional phone call from the counselor for support. As much as possible, the counselor should accept vacillation and reluctance to proceed with treatment. She should not expect the client to make major decisions or begin any big projects during this time of depression. The focus of treatment at this time is to help the client cope with her feelings of loss, to express them directly as much as possible, and to offer support as the client works out her feelings.

Avoiding Mistakes. Counselors tend to make certain common errors in the early stages of the counseling relationship. One such error is the assumption that the client has developed a strong sense of trust in the counselor as a result of preliminary support. Nothing could be further from the truth. It takes more than a few hours of helpful or sympathetic communication to build a real sense of trust. The relationship is still fragile and will have to go through a period of testing and ambivalence before a solid foundation exists for the counselor's interventions.

Therefore, it is important to avoid pressuring the client to make decisions that affect major areas of her life. She has made one major decision in entering treatment, and for a time she will not be able to handle other choices. The counselor may feel tempted to make some decisions for the client during this period, to help the client get control of certain problems or to enable her to obtain certain resources. But the counselor must constantly keep in mind that any lasting change will come about slowly, and that moving before the client is ready may only result in failure. Therefore, the counselor must be prepared for a certain amount of frustration as the client continues to live much as she has for some time.

Another mistake is to ignore statements or actions of the client that indicate dissatisfaction with treatment or express mistrust of the counselor. The client must find out how the counselor will react to negative feelings and actions. The counselor must acknowledge negative feelings and encourage the client to explore the basis for them. This does not mean that the counselor can correct any shortcomings that the client perceives in the treatment program, but in some instances, the counselor can alter the approach to respond to the client's needs. In any case, the client must feel that her counselor is willing to listen with an open mind to her perceptions. In addition, if the client begins to have difficulty in following the rules of the program or in meeting the counselor's expectations, it is wise to confront this problem immediately rather than wait until it becomes severe. This is a good time to clarify the consequences of failure to comply with program expectations. A warning will sometimes be enough to reestablish compliance. It is easier to explore reasons for behavior before the client has to be punished for her actions.

Some counselors have difficulty in interpreting the client's feelings or actions. Interpretation is like pepper--too much of it makes the whole dish inedible. As counselors see possible causes of their client's difficulties, they often want to share these insights. But counselors should be aware that most clients are not ready to reexamine the causes of their behavior or feelings; their first need is to express or explain things to the counselor as they see them. The counselor can suggest that in time they might explore reasons for past and present actions, but it is unwise to indulge in premature diagnosis or sweeping judgments about the client. The counselor would be wise to confine such speculations to the supervision session or staff meeting, to allow for feedback and to evaluate implications for the course of treatment.

Recognizing a Positive Counseling Relationship. Even after several months of work with a client, the counselor may feel unsure about the relationship. The client may be guarded most of the time, may be expressing considerable resentment or dissatisfaction with the treatment program or the relationship, may be attempting to manipulate the counselor for special favors or other gains, or may be continuing to display behavior that is distressing or annoying to the counselor. How, then, can the counselor evaluate whether progress is taking place?

One measure of the relationship is the client's continued participation. If, despite difficulties involved, the client continues in the program, an important goal of the counselor's work has been achieved. Further, if the client has begun to establish relationships with other staff members and clients, she has become progressively more involved in the treatment program and more dependent on it for social satisfactions. In fact, the client's dependency is important at the beginning of treatment. If the client looks to her counselor for help with certain problems or to obtain attention or approval, then the counselor should feel satisfied that the relationship has meaning to the client.

Another measure of success for the counselor is the content of the counseling sessions. If the client brings up a gradually larger number of subjects and reveals progressively more about herself, then she is beginning to trust the counselor and make use of the relationship.

The counselor should continuously assess the process of a typical session. Does the conversation flow back and forth between counselor and client? If the client does all the talking, with the counselor taking a passive role, something may be wrong with the counselor's perceptions. The counselor should not be merely a listener, but must find a way to participate in the counseling process. If the client is silent most of the time, while the counselor asks questions or gives information and feedback, the counselor may be trying too hard to "change the client." The counselor should sit back and force the client to take a more active role. If the client refuses to do so, the counselor should reexamine the relationship to discover what has made the client mistrustful. In a good counseling relationship, the counselor and the client are equally involved in seeking solutions to the client's problems.

Of course, it is important that both the counselor and the client begin to see some progress, especially in terms of the client's short-term goals. The counselor should review these goals with the client every few sessions and discuss what changes have been accomplished and what goals should be altered or discarded in favor of more pressing issues. If there has been no change or improvement over several months, even in terms of short-term goals, then it hardly matters how pleasantly the sessions are going. They are not serving their purpose effectively, and the counselor should explore the reasons for this with both the client and the supervisor.

If goals are gradually being achieved, participation in the sessions is fairly regular and equally shared, and the subjects discussed relate to the client and her problems, then the counselor and client have built a productive counseling relationship.

Fostering Independence. A counselor must at all times evaluate the extent to which a dependency relationship has been established and possible actions to encourage independence. A client will often deny the extent of her reliance on the counselor and the program because she finds the dependency both controlling and humiliating. Nevertheless, the chemically dependent woman will need the counselor's assistance in so many ways that the counselor may be drawn into a dependency relationship. The client will rely more and more on this help as time goes on. Therefore, as the woman learns new social skills, the counselor must encourage her to use these skills outside the treatment setting. In discussing plans for the future, the counselor should specifically mention that the client will have to learn to function independently. In maintaining this perspective, the counselor can help the client explore ways to function more independently as treatment progresses. Although at the beginning the counselor must constantly reassure the client that she can depend on the program and the counselor to help her, the counselor must give the client every opportunity to resolve her own problems. Every time a problem is resolved, the client should be made aware of what she did or could have done to solve it, not what the counselor did. Each problem-solving strategy must focus on the dual objectives of handling the immediate difficulty and making it possible for the client to prevent such difficulties in the future.

> Jane, a 24-year-old woman, was very involved and active in treatment. She had been considering going to school to learn word processing but was terrified whenever she thought about facing tests. When her counselor reminded her that she had done very well in the program, she responded that it was easy to do well with so much help from the counselor, but she had no one at the college to help her. The counselor then pointed out some concrete social skills she thought Jane possessed. The counselor also reminded Jane of the time she had taken a friend to the welfare office and helped her fill out forms. She noted that, in that situation, Jane had been confident and helpful without any assistance from anyone. The client spent some time talking about how she had managed the situation. The counselor outlined the similarities between the welfare office and a college admissions office, illustrating the skills the client had developed in treatment which could be transferred to the college situation. Finally, Jane saw that it might be possible to handle the situation and applied for admission.

RESISTANCE TO TREATMENT

Unfortunately, even when counselors follow the rules outlined in this chapter, they still are likely to encounter resistance from their clients. Often, resistance is related to the client's fear of change. The expression of resistance can take many forms, but all have the effect of *stopping or slowing down treatment*, and therefore discouraging, angering, or frustrating the hard-working counselor. It is helpful to recognize the client's behavior as *resistance to treatment and to change*. Labeling her as stubborn or unmotivated, for example, will not help you understand the resistance, its origins, or how to diminish it. Some examples of resistance are the following:

1. Forgetting the time of the appointment;
2. Having a fight in a group and leaving;
3. Acting helpless in the face of difficulties;
4. Frequently coming in late;
5. Using drugs;
6. Not "seeing" that her behavior is a problem;
7. Not following through on a referral;
8. Dominating a group repeatedly;
9. Rationalizing self-destructive behavior;
10. Attacking or manipulating a counselor;

11. Getting evicted for nonpayment of rent; or
12. Creating any number of other crises.

Some forms of resistance are more upsetting than others, and the counselor should assess the source of resistance as it develops. Whatever its source, staff members should try to avoid feeling undermined by behavior that is at times openly hostile. Equally important, they must try to respond to such behavior without being punitive.

Psychological Factors. Sometimes resistance is attributed to psychological factors. An example often cited in the literature (Reed and Moise 1980) is that the client is likely to begin treatment with a low regard for herself and her ability to succeed. She might feel that she is not worthy of treatment efforts. Because of overwhelming anxiety and low self-esteem, she might convince herself that treatment is a hopeless proposition and leave prematurely. Of the 63,000 women who were discharged from federally funded drug abuse treatment programs in 1979, only 22 percent had completed treatment (National Institute on Drug Abuse 1980).

Women in treatment have developed somewhat rewarding ways of perceiving the world and of responding to problems. Suddenly, they must face these pressures without the help of drugs. They are asked to give up their customary coping patterns at a time when they most urgently feel the need for immediate solutions and gratifications. The promise of improvement in the long run is a poor substitute for familiar, available defenses. Counselors must recognize and address the resulting anxiety that arises in these women.

Situational Factors. As noted, women experience significantly more "reality" problems than addicted men (Reed and Moise 1980). Often, the pressing needs and demands of their families are incompatible with the treatment program's regulations. For example, many women leave treatment because the needs of a child or a sick relative take precedence over scheduled treatment activities. Other women feel overwhelmed after entering school, career training, or a new job and can't find the time to spare for treatment. In such situations (when women's energies are taxed to the limit), the treatment program is perceived as a source of additional pressure rather than support.

Many social and economic pressures also work against the achievement of treatment goals. Without jobs, most substance-abusing women depend on sources of illegal income (i.e., prostitution or other criminal activities) or on some form of public assistance (Reed et al. 1980). When a chemically dependent woman gives up the drug, she is also urged to give up the illegal activities that helped her support a habit. Often these activities, though deviant, represented sources of pride and satisfaction as working roles, and the woman has no replacement for them. No less important, she usually has a loss of income during treatment, and luxuries and even day-to-day staples are suddenly out of reach. This takes away a

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major source of interest and excitement, further diminishing her self-respect. Commitment to treatment becomes problematic when the client feels caught between an exciting and dangerous past and a safer but possibly duller and lonelier future. Little in the present provides sufficient satisfaction to motivate a woman to structure her life around the demands of the treatment program.

In the transition from the drug to the nondrug world, many chemically dependent women also face other difficult life situations, such as poor health, inadequate housing, deviant legal status, and a loss of social supports acquired during the drug-using period. As noted by Bahna and Gordon (1978), many chemically dependent women in treatment cope with loneliness and the fears of dealing with an alien culture--the outside world. The loss of ritual comforts and friends poses many difficulties for the chemically dependent woman. Often in the process of stopping heroin usage, a woman feels that she is indeed a stranger in a strange land. She can no longer "run the streets" and still does not fit into "straight" society. This is an important obstacle in her efforts to change. She may cling to the relationships she has formed while addicted with the feeling that if she deserts those who accepted her as an addict, she will lose her very identity. As noted by Tucker (1980), addicted women entering treatment feel more isolated than addicted men do, and their social support systems are more limited. They often feel so stigmatized by their criminal records or scarred bodies that they find it difficult to become involved in new social groups or relationships.

Systemic Barriers. Chemically dependent women in treatment will often complain about the bureaucratic structure of the treatment program. They perceive the forms and procedures as an annoyance and regard program policies for receiving methadone as a particular source of inconvenience. In residential programs, a woman may find the hierarchical structure and its procedures alien to her.

A client may develop other apprehensions about the bureaucratic structure. She may fear being dependent on and controlled by the treatment program. Even in a positive counseling relationship, both client and counselor will become troubled about the dependency involved. Many clients are tempted to leave treatment to reassure themselves that they can still function alone. Others have overwhelmingly negative feelings about authority fitures and feel compelled to defy rules to prove that they are "free." At other times, the values of the staff, as expressed in activities and counseling sessions, may be in conflict with the values of the woman's family of origin or of her entire culture. For example, she might give up treatment if it involves betraying her family or her beliefs.

There is an inevitable and unpleasant struggle between old and new values throughout the entire process of treatment. Treatment always involves some restructuring of values, so that the beliefs and perspectives that led the woman to depend on drugs are replaced with those that will sustain her in her effort to remain abstinent. This process can often feel painful and oppressive.

In many programs, women may also be reacting to discrimination against women brought into the treatment setting from the larger society (Bahna and Gordon 1978; Soler et al. 1974). "Because the programs are established by men, there has been a continued abuse of sexuality as a way of looking at and dealing with women" (Mandel et al. 1979). Women in treatment express wariness of the treatment setting based on past experiences. They fear that "street" labels will follow them into the treatment program. They know that they will be outnumbered by men in a treatment program and expect that the men will bond together and make sexist remarks. Fearing that they will be severely stigmatized, they often are too discouraged to remain in treatment.

In addition, drug counselors have also been shown to use confrontation techniques in a counterproductive manner for women (Cuskey et al. 1977; DeLeon and Beschner 1977; Reed and Moise 1980), especially during the early phases of treatment when the woman is most vulnerable to "attack."

Drug program staff have also tended to overemphasize women's "psychological handicaps," which encourages resistance. Women may resist treatment because they feel that staff members view them as "sick" and do not emphasize the importance of practical problems such as getting jobs or improving their education (Deren and Koslowsky 1977). Colten (1980a) points out that there are defined reasons for addicted women's anxiety, low levels of personal esteem, and personal distress: "In all, their situations are, at best, dreary, and, at worst, shockingly depressing. If they did not appear more depressed, we might wonder what was wrong with them."

RESPONDING TO RESISTANCE

Many therapists feel that one of their primary tasks is to gradually work through client resistance. If counselors expect and understand this resistance, they can recognize it as an opportunity to respond to the woman as she is, rather than as she wants to be. Counselors can be in better positions to help clients if they experience clients' less desirable behavior and work to help them understand and modify such behavior.

In this section, we present some common patterns of resistance and techniques for minimizing their destructive impact on the treatment effort.

Passive-Deceptive Behavior. Initially, the counselor may be delighted with clients who seem docile and eager to please. The counselor may see no problems until the client suddenly drops out of treatment without explanation. A woman may act out the role of the good client to win approval. She may be afraid to let the counselor see her as she really is. Fearful of judgment or rejection, a client may fabricate stories to gain the counselor's acceptance or to avoid exposing herself. However, she cannot maintain her facade indefinitely. She is likely to withdraw the first time she feels something that doesn't fit in with her presentation or the image she is trying to project. For some women, the counselor's efforts to make contact are so threatening that withdrawal is the only alternative. They may not know how to cope with a relationship, especially a helping relationship.

In working with passive-deceptive behavior the counselor should move slowly and not place any immediate demands on the client. Indirect exploration techniques are often useful. The counselor can focus on small, nonthreatening subjects to help the client relax.

In sensing that something is bothering a woman or that she isn't responding openly to questions, the counselor can return to the subject through the use of a third person who has a similar problem. The counselor might ask the client's advice in helping another woman, e.g., someone who was reluctant to share feelings. Often, the client senses that the counselor is talking about their situation, but this indirect approach allows her to suggest or express things that are on her mind. It is important that the counselor not press her to acknowledge feelings or thoughts, which might cause the client to panic and withdraw. Eventually, she will begin to be more open as she finds that negative feelings do not make the counselor angry. In relating to a woman who invents or exaggerates, the counselor should avoid playing detective. The counselor doesn't have to believe everything the client says in order to help her. It is important to be aware that the client may be trying to manipulate the counselor for favors of special attention through her fabrications. If the opportunity presents itself, the client's reasons for invention can be explored without making the client feel that she has betrayed the counselor.

Crisis-Chaos Lifestyle. Many clients seem to go from one crisis to another, with most of their energies consumed in emergencies. The counselor can see that many emergencies could have been prevented with better judgment and planning. The client may seem to only half listen to the counselor's observations before returning to her complaints. The client may be trying to gain attention through her difficulties, however.

The counselor needs to develop an attitude of detached optimism. It is most important to recognize that clients may be doing their very best to cope with difficult circumstances. The client may have never developed the skills needed for planning, budgeting, and making choices that take consequences into account. The present is everything, and the personal, social, and financial resources available are often inadequate to solve the immediate crisis.

Even with support and assistance, some clients will make few changes in their coping styles or circumstances over the short term. A client may not continue in treatment any longer than she must for legal or other reasons. Although counselors should remain aware of their client's multiple, pressing needs, they cannot expect to make significant changes in the short run. It is as important to show the client how to solve a problem as it is to search for a solution. There is a need for a balance between a therapy role and one that teaches problem-solving skills to help the client become more independent. If the client decides to drop out of treatment, the counselor should not be disturbed or discouraged. The client may have no other choice based on the demands on her life at this time. The counselor should convey to the client that it may take her several attempts before she can succeed in treatment, and that the program will be available when she is able and ready to return.

It is easy to become angry with a helpless client who persists in making disastrous choices. This anger helps to put some distance between the counselor and the disappointing client, but it also becomes another barrier blocking the client from real participation in treatment. Thus, the client's helplessness not only prevents her from progressing toward treatment goals, but it alienates the client from the counselor. Later, after the client becomes hostile or withdraws, the counselor is left with a sense of discomfort and guilt about reactions to the client and feels uneasy about the ability to handle similar clients in the future.

To reduce angry responses to the crisis-oriented client, counselors should always try to assess negative or angry feelings toward clients. At the same time, they must keep in mind that it is their job to understand and go beyond these feelings to help other people. They must avoid being pressured by the client's extreme distress. They also must not feel that it is their duty to "prove" to the client that they can help. It is one thing to want to instill the client with a sense of hope and confidence, but it is another to feel compelled to achieve the impossible in order to win the client's trust. Much of the difficulty the client has in organizing her life in a productive way has its roots in a past that she cannot control. The counselor cannot remake the past or remove all the obstacles. So long as counselors do not take responsibility for the client's problems, suffering, pain, or success, they have no reason to become angry at her mistakes and setbacks.

It is deceptively easy for the counselor to fantasize about how much better off the client would be if only she did everything the counselor advised her. In fact, if the client did comply with all the counselor's expectations and advice, she would only be exchanging one kind of helplessness for another.

In attempting to learn basic skills, the client will make many mistakes. She will go backward at times when it is most crucial for her to go forward. At times it will appear that the counselor is heartless not to step in and handle a situation. At other times the counselor will have to take control of a situation to prevent further damage, e.g., when the client is abusing her children or her health. But these are rare circumstances, undertaken only when the counselor has sought the opinion of other staff members and confirmed that there are no other options.

Another mistake that counselors make when dealing with a woman experiencing multiple crises is to become too calculating and unresponsive. Counselors cannot be so cold and distant that clients cease to look to them for support. The counselor should expect to supply some part of the effort needed to resolve problems faced by clients. That part may be simple discussion of the alternatives in a calm, concerned atmosphere. More often, particularly during the early phases, it involves obtaining information concerning resources, advocating for the client with the welfare department, arranging for emergency foster childcare, or taking other direct steps.

Dealing with feelings of helplessness, guilt, worry, and anger in a peer group or supervision session is a necessity for counselors working with this type of client. They need a setting that offers acceptance and support. They need the perceptions of others who can be objective to help them assess situations, particularly those in which they feel personally involved. Ultimately, they will need help to accept the limited progress the client makes before leaving treatment.

Anger and Hostility. At times, every client can become angry and attack the counselor with words, either directly or in talking with others. Anger is a necessary behavior in a relationship that can mean so much to a client. It is an appropriate reaction to the fear of being controlled. It is also a healthy reaction when one feels rejected, abandoned, judged, used, or mistreated. Whether or not the client is "right" in her perceptions, she must find a way to express negative emotions. It is important to distinguish between occasional anger and hostility in an otherwise productive relationship and one in which angry expressions are the primary means of communication between the client and others. Some clients may use hostility as a defensive maneuver to direct attention away from their own behavior. At times, a client will become hostile to fend off positive feelings and experiences in fear of a dependent relationship.

Counselors must know how to handle hostile behavior without becoming hurt, defensive, or punitive. They should share their inner reactions to the angry attacks of clients in supervision or peer support settings. They may find that clients are testing them or are vulnerable to something the counselors say or do.

Counselors must not be so intimidated by verbal attack that they abandon their roles as counselors, limit setters, educators, and treatment planners. They must not be afraid to criticize client behavior, when warranted. They also must not withdraw from clients and cease to work toward treatment goals. The counselor who avoids these reactions has a good chance of weathering the hostility until the underlying problems are recognized.

It is helpful to explicitly identify hostile actions and words in contacts with the client. In doing so, counselors can take the focus off their own feelings and give the problem back to the client. For example, a client who couldn't get a job began yelling at the counselor about what constituted a good job. The counselor responded: "You might be right about that. But right now, you are avoiding the problem. I wonder how your anger is going to help you deal with your job problem." Here, the counselor avoided getting into a philosophical debate about what constitutes "real work" in favor of shifting the attention back to the client's problem. This might have to be done repeatedly to get a client to talk about an especially threatening topic.

There are times when the client is so hostile that work cannot go on until the client begins to alter her behavior. It is important for the counselor to point this out:

> If you want to continue to criticize and attack me, you're free to do so. I'm not going to be able to do anything to help you with your housing problem until you stop. It's really up to you. You can leave now and stay mad, or you can calm down and let me explain how we can work together on this.

Often, the client would like to strike out at someone for the frustration she feels. If counselors give the impression that they are willing to be used as punching bags, they will find themselves subjected to repeated abuse. The same is true for physical violence. Any program that tolerates physical attacks and intimidation cannot function as a treatment setting because the counselors will be too afraid of their clients to challenge their behavior effectively. Counselors should set firm limits on the amount of hostility they will accept from clients. They may decide that 5 minutes out of the session is enough. They can inform clients that although they understand that they need to be angry at times, they are willing to accept such behavior only for a limited time, and if the client cannot stop at that point, the session will be over for that day. This gives the client some room to ventilate without turning the counselor into a doormat. In addition, the client who uses her hostility to keep the counselor from getting too close will achieve her goal without causing the counselor unnecessary pain.

Defiance and Rebellion. It is not easy to enforce limits or program rules, but most women in treatment will test to see how serious the program is about its regulations. This testing may take the form of a few late arrivals, missed appointments, or use of drugs. The regulations and demands of the program may be too difficult for a woman to meet. Her bad habits will not disappear without a struggle. The counselor who understands these factors will not be upset or surprised at the woman who breaks a rule, or breaks several in the first few weeks of treatment. The counselor should apply limit-setting skills, offer information on the possible consequences of the client's behavior, and provide support to make it possible for the woman to comply in the future.

The woman who breaks rules regularly presents more serious difficulties. She challenges the counselor openly, defying authority and laughing at reactions. She implies that the rules are foolish. Any loss of control on the part of the counselor will appear to amuse the client. Sometimes a client who was making progress will suddenly respond with defiance to a counselor. This represents a loss to the counselor, who feels a sense of failure and betrayal.

When testing and defiance develop, it is generally safe to assume that the client is afraid of losing something. She may be attempting to cling to a sense of autonomy, even at the cost of endangering her treatment. The counselor must assess the situation and try to identify underlying reasons for the behavior. The counselor can go back to the information gathered during assessment to see if there are any clues. The counselor can also look at the treatment process to see if any new issue or expectation might be triggering the client's actions. It may be that some clients are ambivalent about treatment. They would rather provoke the program into discharging them, proving to themselves that they do not deserve treatment, and at the same time blaming the rigidity of the program for being rejected.

The counselor who understands these underlying dynamics can discuss them with the client, pointing out the client's actions and asking whether the client is sure that this is the outcome she wants. The counselor must keep in mind that it is not productive to express anger toward the client. The client must decide whether to submit to the program's authority in order to obtain treatment. Submission requires humility. She is admitting that she does not know how to live, and that she needs someone to help her. It is helpful, in this situation, to point out that the program is asking a great deal. The counselor can point out exactly what the program offers in return for the autonomy it takes away. The final decision is up to the client.

Helpless, Self-Destructive Behavior. Every woman who enters treatment has some desire to stop her self-destructive behavior, if only for the sake of a child or loved one. The counselor is often presented with a woman who feels powerless to protect herself. She may have been beaten by a man or forced to become a prostitute or to steal so that her husband or lover could buy drugs. She may drink, use prescription drugs for a diet or pain, or use other self-medicating methods.

Counselors also feel a sense of helplessness in working with such clients. They cannot stop a client who seems determined to undo what had been accomplished. Here we have the reason for the anger the counselor feels.

The first step for the counselor is to assess the severity of the problem. Is the client doing severe, irreparable harm to her body? Is she risking arrest? Is she exposing her children to severe physical or emotional damage? Counselors should assess how much "leverage" they have over the client. Can they use the relationship

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established with the client? Is the client dependent on the program for her physical or emotional needs? Is she forced to remain in the program or go to jail? Counselors should not be afraid to use their authority to remove clients from dangerous situations. They may decide to call the child protective services to report child abuse or neglect, or to recommend the children move to a foster home to prevent the likelihood of abuse. Such action should be explained to the client directly:

> I am concerned. I care about you too much to just sit by while you hurt yourself (or your child). I am going to stop you. I know you may not understand or agree. You may be very angry, but at this point, I have to protect you. You will be able to protect yourself when you feel better but I am not willing to watch you do things that can't be undone, things you have done in the past and regretted.

The client is likely to be angry but is likely to eventually recognize that the counselor's actions were helpful.

At times, the counselor does not have sufficient leverage to control the client's actions. At the beginning of the treatment process, the counselor faces a dilemma. To do nothing is dangerous, and leaves the client unprotected. Further, the client may perceive the counselor's inaction as indirectly supporting the destructive activity. In taking a controlling position, the counselor risks alienating the client.

> Teresa, a 30-year-old woman, had been in treatment previously and had done relatively well. She had held a secretarial job for 3 years and had been seen as a success by the staff. Then she married another client, a man who soon dropped out of treatment, taking Teresa with him. He was arrested a few months later, leaving Teresa pregnant. She lost her job when health problems arose related to the pregnancy. The staff members heard about her problems and sent her a letter inviting her to return to treatment. She returned a few weeks before the baby was born, worried that the baby would be born addicted.
>
> After the baby's birth, Teresa was very depressed. She felt ambivalent about being a mother, and resented the demands the baby made on her. She also resented her husband for leaving her to cope alone. She missed her former friends from her job, and felt left out when they went to parties while she stayed home. After a few months, it was noticed that the baby had bruises and welts, which the mother explained as falls or accidents. The staff did not believe her; the counselor attempted to convince the mother to place the baby in a day care center and return to work.

> At this point the husband returned from jail. Soon, Teresa came for appointments with numerous injuries and admitted that he had beat her because he "couldn't stand listening to the baby cry." She said he had a gun and had threatened to kill her and the baby if she didn't shut the baby up.
>
> The counselor urged Teresa to leave her apartment immediately, secured emergency shelter for mother and child, and, with another staff member, helped her move there. Teresa, however, soon returned home to her husband. The counselor suggested couple counseling but the husband refused. When Teresa missed her regular appointment, another client visited her and reported that Teresa had been beaten again, and the baby's arm was broken.
>
> The counselor called protective services and a worker investigated but did not take any action. Teresa stopped coming to the center. Her counselor felt discouraged and frustrated.

At a staff meeting, another counselor suggested that although the abuse was frightening, the counselor had no way of stopping it directly. She felt a useful alternative approach might be based on Teresa's need to return to work. A job might help her feel more independent and less depressed, and she would be less likely to tolerate abuse.

> The second counselor then contacted Teresa offering to help her brush up on her secretarial skills and find good child care. She did not mention the marital situation. Teresa came in and the second counselor referred her to employment agencies, role-played job interviews with her, and went with her to visit childcare centers, securing welfare department assistance to pay for child care. Another client provided transportation for a minimal fee. She gained more confidence on several temporary jobs, and eventually accepted a permanent position.
>
> Teresa never resolved the conflict with her first counselor, but did leave her husband when he beat her again. The second counselor helped her borrow money for a rent deposit and locate an appropriate apartment for her and her child. She was also supportive during the anxious periods after the separation.

This case illustrates the problems and potentials involved when a client could not accept direct intervention in a destructive situation. The second counselor recognized that Teresa was unlikely to separate from her husband while feeling depressed and dependent. This counselor worked to increase Teresa's self-esteem through constructive action on Teresa's wish to be employed. This required counseling support, coordination with other agencies, skill training (interviewing for jobs), and advocacy.

In many cases, there is no clearcut point when the counselor feels forced to take action. The client merely continues a longstanding pattern of tolerating physical or mental abuse. In such cases, the counselor might attack the problem indirectly, similar to the second counselor above, building on a productive relationship that makes it possible to intervene effectively. The counselor needs to discuss with the client any activities she sees as self-destructive and include work on these activities in a treatment plan with the client's active participation. This is generally a long-term process.

WORKING PHASE

As the client and counselor identify and manage initial and later resistances to change, significant changes in the client's life begin to be possible. Many areas we discussed here will also have been important earlier in treatment, during times of crisis management, and while the woman is entering the treatment process. During this period, however, the counselor and client can work more intensively to develop life patterns, coping skills, and support networks that will allow the woman to stay drug free and develop a more satisfying and productive life.

Practical Problems. Counseling must continue to be augmented by practical help in obtaining concrete, tangible services, such as income assistance, childcare, housing assistance, or legal aid (Pittel 1976). The client may need accompaniment to a court hearing, transportation to a doctor's appointment, assistance in managing her money, help in fixing her car, advice about sound nutrition, or help in obtaining emergency loans. All the above are coping skills that must be learned before she can live successfully in "straight" society.

Chapters in this book are intended to provide counselors with how-to-do-it information that will be useful in helping women clients acquire the practical services they need, i.e., legal, vocational, medical, childcare, parenting, and health promotion.

Access to Community Resources. When services are not available within the treatment program, the counselor must learn about all the resources available in the community. When seeking other community services, two factors should be considered:

- Whenever possible, use traditional universal resources rather than resources that might stigmatize the client. For example, check into college vocational training, rather than CETA. Consider whether the resource will help the woman leave behind her "deviant" label.

- Have accurate information available about crisis resources, such as emergency childcare, legal assistance, temporary housing shelter, or food. The client is most likely to seek help in crisis situations, and even if the counselor doesn't have a solution, sincere efforts in attempting to deal with real problems will communicate concern to the client.

If the program cannot provide the comprehensive medical and dental services needed, the counselor must assume an advocacy role to insure that clients obtain quality care and that medicaid or other third-party payment methods are available for women who qualify for them.

Vocational Issues. "Frustrated" is the word that describes many women addicts during reentry as they try to find gainful employment. As Bahna and Gordon (1978) observe, "Criminal records had closed many doors to them, while lack of skills and education precluded many careers. Low-paying, low-skill jobs are often all that is available to them. . . ." Contrary to stereotyped ideas that women need less vocational assistance because they will be homemakers or mothers, data suggest that chemically dependent women are more in need of vocational assistance than men are (Colten 1980a; Gearing 1973; Levy and Doyle 1974; Reed and Leibson 1981).

How can counselors change the negative images addicted women have of themselves vocationally, and how can they redirect their own thinking to help women acquire jobs? Reed and Moise (1980) advise counselors to help women obtain their high school equivalency through GED or adult education programs. They point out that it may be necessary for counselors to pose career options early in treatment so that clients have time to prepare themselves for future opportunities.

Some feel (e.g., Colton 1980a) that women ". . . may find it necessary to breach certain aspects of traditional sex role boundaries in order to survive. . . ." Bahna and Gordon (1978), however, caution that as women "raise their level of aspiration, they should be gently encouraged without any attempt to impose goals and values upon them. Treatment expectations should be in line with what each woman herself desires, while staff should be sensitive to the low self-esteem and lack of skills and education which hold women clients back."

Steps and strategies for developing vocational rehabilitation services are described in chapter 8, this volume. The counselor can help the client in this process in several ways:

- Identify experiences that the client values and receives meaningful rewards from.

- Raise her expectations by encouraging her fantasies and helping her integrate some of them into her goals.

- Explore her interests (via past accomplishments, hobbies, people she admires).

- Pace your interventions slowly, developing attainable short-term goals that are steps toward a future life she can visualize.

- Build on skills she already has.

Organizing a group of women to focus on vocational interests can be useful because many women with chemical dependency problems are either completely unfamiliar with educational and vocational training opportunities or have been discouraged from seeking those services. Clients must be informed in concrete terms of the programs and resources, financial and otherwise, that they will need to pursue vocational preparation. Both short- and long-term training should be presented in a variety of interest areas. If a woman is interested in business, offer information on sales and opportunities. If she is artistic, suggest careers in graphic arts or interior decoration.

> Mary saw herself as a 39-year-old, "very tired" prostitute who was too tainted, too old, and too unqualified to get a decent job. Despite the client's protests, the counselor persisted in helping her define interests and skills. After considerable exploration, Mary revealed that while in prison, she was a head cook and supervised four other women in the daily preparation of meals for 1,000 inmates. She casually mentioned that she had to be very well organized to closely supervise a transient, indifferent staff, handle inventory, and improvise a menu when supplies were short. Although she relayed this experience with pride, she was astounded when her counselor interpreted this as managerial experience. The counselor carefully researched job leads in entry-level positions and located a fast-food firm known to accept former addicts in such positions. She then helped Mary make out a resume that included her prison experience and helped her face fears about being rejected by middle-class, straight people. Within a few months, she was accepted into the restaurant training program with a fast-food firm at a beginning salary of $14,000 a year and a planned schedule of promotions upon completion of training.

Although this approach may seem unrealistic, counselors should recognize that many women with drug problems are bright, competent, and capable of sacrifice and long-term commitment. The goal of the counselor is not only to help her find a job matching her skills but to raise her sights to careers worthy of her commitment.

Relationship with Children. Counselors should also recognize the concern and responsibility addicted women have for their children (Colten 1980b; Ryan 1979). Women entering treatment usually have few childcare resources. These women will need special supports not currently available in most treatment settings. Many need permission to bring their children with them when they meet with their counselor. At times, home visits or telephone contacts will have to be arranged because these mothers will be too involved or exhausted by their parenting responsibilities to keep couseling appointments.

In offering counseling, the woman should not be asked to choose between her children and treatment. Counselors should consider conflicts that the mother's parenting responsibilities create. Often, she becomes dependent on others for childcare, even though she has few personal resources to rely on.

> My mom is coming down on my case real hard. When I was in jail for 8 months, she took care of Leticia just fine. Now, she refuses to babysit her if I have to go to my workshops or for job interviews. I know my mom is just trying to get me to be responsible for my own kid, but I can't afford day care.

This client might subscribe to traditional values and feel frustrated by her inability to meet her own high expectations of herself as a mother. She is likely to have strong reservations about putting her children in a day care situation while she attends school or treatment.

> I don't want to put my baby in any childcare center. It just isn't right to let strangers around her. If my sister or my mother can watch her, fine. But I'm not going to be one of those mothers who doesn't care who they give their children to. Women like that don't deserve kids in the first place.

The woman can be encouraged to put her child in a play group or day care center for a few hours a day and should be helped to find childcare resources that will be sensitive to her needs (see chapter 10, this volume). She should be encouraged to recognize her need to be away from her child as well as the developing child's need for separation.

Other types of help with children should be explored. Parent effectiveness training, or workshops in child development, can help the woman alleviate feelings of guilt or worry and become more effective in her parenting (see chapter 11, this volume). In addition, the woman may need help in securing medical help or welfare benefits for her children or may require help in sorting out her children's emotional or school problems. All of the practical problems women face in caring for their children suggest that services designed to meet their diverse needs are essential if counselors wish to work effectively with mothers over time.

Relationship With Her Man. Many counselors have found that a woman's relationship with a man may interfere with the treatment effort. Reed and Leibson (1981) suggest that relationships with men who are using drugs and who may not be supportive of women's seeking treatment are a factor in preventing women from entering treatment programs. In fact, some residential or methadone programs work to separate the woman from her husband or lover (Cuskey et al. 1979).

Often, the counselor perceives her client's relationship as destructive or too dependent. The woman may experience frequent physical or verbal abuse. Her man may use drugs, see other women, refuse to contribute financially to the household, or block her from seeking support elsewhere. This stereotype emerges so often in drug treatment with other women that counselors often conclude that their first task is to separate the woman from her man. But the counselor usually finds that the woman is ready to sacrifice the treatment relationship if it threatens her relationship.

> Maybe Jim is not the most reputable person--he deals and steals to support his habit. Sure, some might call him an undesirable, but he's all right with me. He's my little bit of security--it's not much, but it's all I have. I know if I need him he's there. When I was broke and in the streets, he sent me money off his books from the pen. Why, he's been the only father my kid's known; he treats her like his own. I don't think any square can understand or accept my relationship with Jim. If my counselor told me to leave Jim, I'd get rid of her before leaving him.

Before making premature and often ill-advised judgments about the woman's relationship with her man, it is imperative that the counselor consider why the woman wants to maintain the relationship. To be effective, the counselor must view the relationship from the client's perspective. For example, she may receive security, companionship, sex, and adventure. Even when the man is not providing gratification, the memory of past rewards creates an expectation of good things to come in the future. The status of having someone to rely on may be critical to her. She may not believe she has the capacity to make it on her own. Serving this man may, in fact, be her only fulfillment or purpose in life.

A woman in this situation will have to make many changes--gain new experiences, and develop her coping skills and self-image--before she can challenge a relationship and consider the possibility of making it alone. She must begin to believe in her right to succeed and in her ability to seek out gratifications directly.

Relationships With Women. Chemically dependent women may not value themselves (Beckman 1975; Colten 1980a) and may not value their relationships with other women. Recognizing the similarities between their situations and those of other women can be an important component of treatment. Learning to rely on and respect other women and seeing how women can help each other can lead to valuable friendships, larger and more helpful support systems, and more self-respect. Women's groups and activities and many women role models can be helpful.

The counselor should also remember that not all women will be interested in developing intimate relationships with men. Some will be strongly woman oriented socially. Some may define themselves as lesbian. Others may be confused about their social and sexual preferences. Many variations in relationships exist and can be meaningful among women. These relationships should be explored as a part of counseling.

TERMINATION PHASE

We cannot discuss the full range of activities involved here, but the counselor must always plan toward an eventual termination. Most women will terminate before all treatment goals are realized. They may drop out because they anticipate the counselor will not approve, or because they can't handle a planned separation. Many counselors question a client's readiness to handle her problems on her own. They may feel angry, rejected, or overprotective when a client wants to leave treatment before the counselor feels she is ready.

Our advice about unplanned terminations is simple but hard to follow: Call the woman or seek her out, recognize her gains, and say goodbye. This makes it possible for the woman to feel supported in her decision, relieves her guilt, and helps her to feel finished with the treatment process and ready to move on. She may return later, or may seek out other supports as a woman, rather than as a drug addict. One evaluation study (Cuskey et al. 1979) reported that although most women dropped out early in the treatment process, most also had not reverted to addiction or criminality and felt they had made gains in treatment.

As Reed and Moise (1980) suggested, the process of treatment from the beginning should emphasize expanding the woman's social skills and supports outside the treatment setting. If this has been a focus of treatment, there is no need for regret or worry when the client leaves. It is fine to let the client know you will miss her and are sad to have to say goodbye. If the relationship has been positive, she will need to express similar feelings. However, successful treatment prepares the woman to move into new circumstances, new roles, and away from the stigma and distress of the addict lifestyle, including addict-identified treatment. Once in a while, you may even be able to plan a gradual termination with a client, with longer periods between appointments, practice in surviving without counseling, development of useful support groups or relationships, clear and realistic future plans, and a celebration.

COUNSELOR BURNOUT

Counseling chemically dependent women is a challenging job. A counselor must be able to deal constantly with hardship and emotional stress and pain and still maintain the caring and commitment needed to carry out the job. Otherwise, the process of burnout

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begins. The social and psychological dimensions of the burnout syndrome can be devastating. Burnout can involve a loss of concern for the client; the counselor might develop a cynical dehumanizing perception of her clients and their problems. Or the counselor may feel helpless or be overinvolved with or overidentify with a client.

Our experience has shown that several factors are important in protecting the counselor from burnout. Some clients have problems that are more emotionally draining for counselors than others. For example, some counselors feel tremendous stress and frustration in dealing with cases involving wife battering; some, however, are not particularly devastated by such cases but find situations involving child neglect or abuse to be emotionally overwhelming. What is emotionally painful for one person may not necessarily be burdensome to the next. Counselors must identify client problems particularly stressful for them.

Counselors who feel ill-equipped to deal with certain situations or clients should be allowed to shift their caseloads. If poor or inadequate relationships develop between a counselor and a client, steps should be taken to transfer that client to another counselor in a way that does not stigmatize the client.

Supervision should be structured to provide counselors the opportunity to vent frustrations and receive constructive feedback. Working with chemically dependent women will be upsetting and, at times, depressing. Counselors need all the support they can get from each other to ward off feelings of failure and ineffectiveness. The counselor also needs a nonjudgmental, open atmosphere in which to share feelings, explore new avenues, and learn how to work more effectively with clients.

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5.

Developing and Managing Referral Linkages for Drug Dependent Women

Judith Kovach, M.A.

This chapter has four major goals. The first is to describe why comprehensive and well-managed referral systems are necessary for most programs serving chemically dependent women. The second goal is to delineate the types of community services and resources needed by chemically dependent women. The third is to outline how to identify client needs and determine where and how to obtain resources to address those needs. Advantages and disadvantages of obtaining services through referral linkages will be discussed. The fourth goal is to present ways of developing, maintaining, and evaluating the effectiveness of referral linkages. Different models for organizing a staff to implement and maintain an effective referral network will be presented. Tools and materials that your agency can use or adapt are presented throughout.

The primary focus of this chapter is the enhancement of substance abuse treatment through use of a referral network. Readers should recognize, however, that community linkages provide additional benefits for treatment programs, including casefinding, organizational and administrative supports, and mechanisms to promote client independence.

WHY ARE RESOURCE LINKAGES IMPORTANT?

Traditionally, the "success" of treatment for chemical dependency has been viewed in terms of client abstinence. Although this is clearly an important and valid treatment goal, it cannot and should not be the sole or even the predominant criterion of individual or overall program treatment success.

Increasingly, it has become apparent that most, if not all, clients in treatment for chemical dependency need extensive resocialization to obtain and maintain abstinence. The National Polydrug Collaborative Project (Wesson et al. 1978) concluded that "the single most important fact that has surfaced from experience with substance users is that they are individuals with multiple needs." The

Women's Drug Research Project (Reed and Moise 1979) findings show that chemically dependent women tend to be more isolated from social and community agencies and support systems than nondependent women and chemically dependent men are. Thus, relative to men in drug treatment programs, women are likely to need more help in developing working relationships with people and agencies that can help them. By learning how to establish and use these relationships or "linkages," chemically dependent women will depend less on other individuals for support.

Thus, one goal of treatment is to help women develop problem-solving and socialization skills, such as abilities to obtain resources, find more productive ways of using time, and improve relationships. The resocialization process requires services rarely provided by drug treatment programs--vocational rehabilitation, housing relocation, recreation, and psychotherapy, for example.

In addition to resocialization needs, chemically dependent women are likely to have problems that can severely impede the recovery process. These problems--medical, dental, legal, childcare, to name a few--are generally beyond the scope of drug treatment programs. Without these supportive services, the likelihood of successful treatment is clearly diminished. In most instances, such services must be provided through referral relationships with other community resources.

Numerous studies have documented the need for supportive services in treating chemical dependency and have supported the need for comprehensive treatment models. It has been shown that a comprehensive treatment approach is even more critical in treating chemically dependent women than it is for men. The Alliance of Regional Coalitions (National Research and Communications Associates 1978) points out that successful treatment programs are those that are "comprehensive and responsive to individual needs; [and] involve the social, family, environmental, emotional, behavioral, and physical aspects of a woman's life." Findings in this report show that low retention rates for women are directly related to the failure of treatment programs to identify or provide assistance in addressing problems other than drug use. Researchers have found that women entering treatment require a greater number of services (as well as different services) than do men entering treatment (Beschner and Thompson 1981). Ryan and Moise (1979) documented that chemically dependent men more often seek legal and employment assistance, whereas women more often seek medical and social services. A regional report submitted to the Alliance (National Research and Communications Associates 1978) concluded that "what is available in drug and alcohol treatment is typically not denied to women but is not specifically geared to their needs."

Based on recent studies, several investigators (Andersen 1980; Beschner and Thompson 1981; Finnegan 1979; Reed and Moise 1979) suggest that a number of basic services should be available to all chemically dependent women in treatment. The Alliance reports emphasize that "services need not be provided directly by a drug abuse or alcohol treatment program, but should at least be available through referral."

The following are some of the services identified by the Alliance:

- Childcare, including day care, foster care, and parent training;
- Educational and vocational programs to develop job and job-seeking skills;
- Medical services, not only for coexisting health problems, but also for prevention;
- Legal services, particularly to address divorce, family, and child custody issues;
- Mental health services, including intensive psychotherapy, testing, and family therapy;
- Housing, emergency shelter, and relocation services;
- Recreation and leisure activities, including skill development; and
- Financial assistance.

Before discussing the development of specific linkages with community resources, it is important to review other factors that must be considered in developing referral linkages for chemically dependent women. We will review the potential impact of these factors on the referral process and show why it is important to consider them in network building. Techniques for addressing these factors will be discussed in later sections of this chapter.

Levy and Doyle (1977) found sex-related differences in drug treatment programs serving male and female clients. Further, staff members justified these differences on the basis of sex role stereotypes. Among unemployed clients in their sample, Edwards and Jackson (1975) found that men in treatment programs were significantly more likely than women to be referred by counselors to job placement services.

Although training programs cannot be restricted by sex, women are often steered into traditional low-status, low-paying jobs--nurse's aide, food service worker, and other service occupations. Men are encouraged to enter higher status, more lucrative areas, such as skilled trades. The reason for this discrepancy is more often a function of staff stereotypes and traditional belief systems than of overt agency policy.

Some agencies have policies that do reflect biases against women. Stephenson (1977) states the following:

> Many mental health theories reinforce cultural assumptions about women--that woman's prime, if not only role, is to be wife and mother; that woman's place is to nurture man; that women in order to be considered mentally healthy, should be submissive, dependent, compliant, sensitive, emotional, unassertive. Healthy women are expected to be content with, or actually seek out, a life of self-sacrifice, in which needs of others are seen as more important than their own.

Stephenson recommends that when appropriate, professionals should help women see their difficulties as "stemming from realistic environmental hurdles, rather than self-limitations."

A crucial issue to be considered in providing services to chemically dependent women, either directly or through referral, is the relationship between a woman's childcare responsibilities and her ability to participate in treatment. The WDR project (Reed and Moise 1979) found that 73 percent of the addicted women studied had children. Further, these women were more likely than the nonaddicted comparison women to have children and less likely to be involved in a supportive relationship in which childcare responsibilities were shared. The absence of childcare is often cited as a primary reason for the low retention rate for women in many programs. Childcare issues must be addressed, in many instances, before other needs can be met. Most programs serving addicted women find, then, that initial efforts must be directed toward locating and developing linkages with childcare resources. In chapter 10, Blasinsky describes how treatment programs can offer quality child day care services to women by establishing linkages with public and private day care services.

The chemically dependent woman's need for childcare services goes beyond the need for physical care of her children while she participates in treatment and rehabilitation activities. Previous research (Eldred and Washington 1976; Ryan 1979) has suggested that women may enter treatment because of concern about the effect of their drug use on their children and a desire for help with parenting skills. Providing training in parenting skills may be a pivotal service in the rehabilitation process because it can affect a woman's sense of adequacy and proficiency, which have been noted as deficient in addicted women (Colten 1977). Improving a woman's level of self-esteem and confidence as a parent may increase the chances of successful participation in other skill development activities.

Chapter 11, this volume, describes how to organize, administer, and evaluate parenting programs for chemically dependent women and their children. Drug abuse programs should consider the needs of children of women in treatment during the planning and implementation stages of network building. It is particularly important to understand that services, regardless of their potential for helping women, cannot operate successfully in isolation. Childcare is one service that must be available to facilitate use of other services, which in turn support the rehabilitation process.

Many experts believe that treatment for chemical dependency can be successful only when abstinence is viewed as an intermediate treatment goal. In other words, more fundamental personality and lifestyle changes must occur to insure that the client maintains abstinence and does not revert to substance misuse as a coping mechanism. Primary stress occurs when a person cannot or does not feel assured of his/her ability to satisfy basic needs, such as food and shelter.

Historically, women have been poorly prepared to meet basic needs alone or to obtain basic resources necessary for survival. In modern society, meeting such basic needs depends in large part on the ability to earn (and manage) money. The average earned income of women is only slightly more than half that of men. Regardless of whether a woman earns money or receives it from the social service or welfare system, she must be assured that financial lifelines for basic survival are maintained. Many women in treatment have never learned how to provide their own support or how to meet their needs through the social service system. Thus, in building a community resource network, it is necessary to concentrate first on services that meet basic survival needs, even if other services have more long-term value for changing lifestyles.

The treatment program must assess potential resources in terms of their ability to address specific client problems, rather than their ability to provide general services. Legal services are an example of this difference. Research has shown that men receiving treatment in drug programs are more likely to have past and current contact with the criminal justice system than are women (Reed and Moise 1979). Chemically dependent women are less likely than men to be referred to treatment by the courts and less likely to require legal defense (Burt et al. 1979; James 1979). However, women need legal services for protection (i.e., as victims of domestic violence and civil and family legal matters) more frequently than do men. As noted previously, women are more likely to have custody of children, and their legal needs are often related to divorce and child support. In establishing linkages with legal assistance agencies, the treatment facility must determine which aspects of legal aid will support the client in obtaining a greater measure of self-esteem and independence.

The final caveat in building a network of resources concerns the importance of recognizing that it is not enough to delineate special needs of women. Differences among subgroups of women also must be considered. Factors such as socioeconomic level, ethnicity, race, age, and sexual preference are likely to indicate different sets of needs and therefore require different service components. For example, treatment programs that serve ethnic groups understand the value of having counselors and other staff who can speak the clients' native tongue and who can identify with the cultural context in which addiction developed and in which rehabilitation must occur. Programs serving special populations of women must attempt to locate community resources that are culturally relevant.

ASSUMPTIONS AND TERMINOLOGY USED

Substance abuse treatment programs exist within a larger environment (e.g., communities, counties, States) that contains an array of other agencies, organizations, and community groups. Many provide services and activities necessary or desirable to rehabilitate chemically dependent women. In this chapter, these services and activities will be referred to as community resources. They include different types of training (e.g., schools, vocational rehabilitation programs); spiritual, emotional, and social support (e.g., churches, social clubs, women's support groups); basic assistance (e.g., hospital emergency rooms, departments of social services for food stamps, emergency housing, public assistance, and crisis centers); childcare services; and specialized therapy and counseling (e.g., family service agencies, mental health centers, rape counseling centers). Although each agency has specialized goals (most likely related to substance abuse treatment), it probably cannot achieve those goals without establishing relationships (referred to as resource exchanges) with other organizations and agencies.

Relationships with agencies and organizations will vary in their degree of formality. Some may develop into formal contractual agreements through which outside agencies provide particular services to a certain number of clients in a specified time period. Other relationships might involve clearly established referral mechanisms to facilitate the intake and recordkeeping procedures. And some may involve informal relationships among staff members in different agencies. In some cases, an informal or simple referral agreement may evolve into a special program sponsored by two or more agencies. Regardless of the degree of formality, this chapter will refer to interagency and interorganizational relationships as linkages and networks.

A systems approach to service delivery and treatment views an individual or agency as operating within a larger environment (system) with many independent and interdependent subsystems. Figure 1 provides a graphic representation of this approach.

In a systems approach, comprehensive treatment is based on the relationships among subsystems in the larger environment. Family relationships, legal problems, relationship to the workplace, and friends are a few of the subsystems that must be considered in establishing and implementing a treatment plan. (Traditional treatment, however, focuses primarily on individuals and their perceptions of and responses to the environment.)

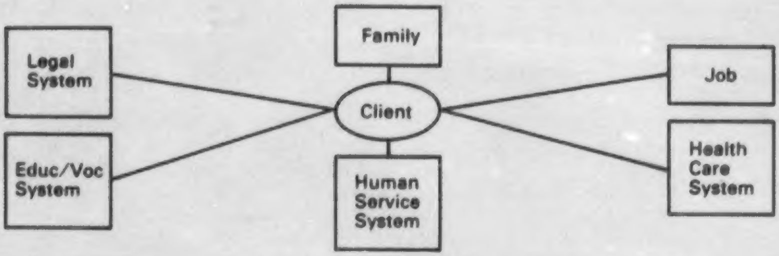

FIGURE 1. Systems approach to service delivery and treatment

DEVELOPING AND MAINTAINING A RESOURCE EXCHANGE (REFERRAL) NETWORK

Although the precise nature of the network and procedures needed may differ among agencies, the process of developing and maintaining a resource exchange or referral network requires several common planning and implementation steps. These steps are outlined in figure 2 and described in the following sections of this chapter. Programs can use this outline to help them do their own planning.

STEP 1: ASSESS SERVICES AND RESOURCES NEEDED

Composite Eco-Maps. The first step in establishing a community resource network is to determine needed services and linkages. One of the more successful methods for obtaining these data is the use of "eco-maps." Eco-maps have been used to assess human as well as biological and physiological networks. Hartman (1978) points out that human beings must create and sustain elaborate social, economic, and political structures to meet their needs.

The eco-map provides a graphic picture of an individual's relationships to family and friends as well as to the structures or institutions, such as churches, human service agencies, schools, and judicial systems, available to meet needs. In other words, eco-maps provide qualitative and quantitative information about an individual's human resources. Based on an understanding of the problems presented by clients, the eco-map also provides the therapist with a view of the resources that have and have not been tapped.

By combining and analyzing the data obtained for a significant number of clients, the treatment agency can develop a composite

Step 1: Assess services and resources needed by the agency and its clients.

Step 2: Assess the resource capability of the agency.

A. Identify services currently being delivered; assess their goals, effectiveness, priority within the agency, and the amount of resources expended versus benefits received by clients.

B. Identify services that could be delivered within the agency and requirements for effective delivery.

C. Identify services needed but not possible to deliver within the agency.

Step 3: Evaluate referral versus in-house delivery of services, weighing and balancing goals, degree of effectiveness, and costs against benefits to clients and agency priorities.

Step 4: Identify sources of services needed by clients but not offered by the program (community survey).

Step 5: Assess and evaluate capabilities and services available from appropriate community resources.

Step 6: Begin development of resource exchanges with community resources.

FIGURE 2. Resource exchange networking: developmental steps

eco-map that will indicate the linkages established and the linkages needed by its client population. The treatment program can then begin ranking the relative importance of various linkages by analyzing composite data; knowing which linkages have high priority for clients has important practical value. Establishing a network requires considerable staff time and effort. Since staff time is almost always limited in treatment programs, the most critical linkages should be established first.

Developing an agency eco-map such as that shown in figure 3 is a good way for a counselor to begin the process of developing referral networks.

Compiling composite data from a particular client population is the most precise way to determine needed services and resources for that group. More general research data also have value, however, and should be considered by any program that is assessing

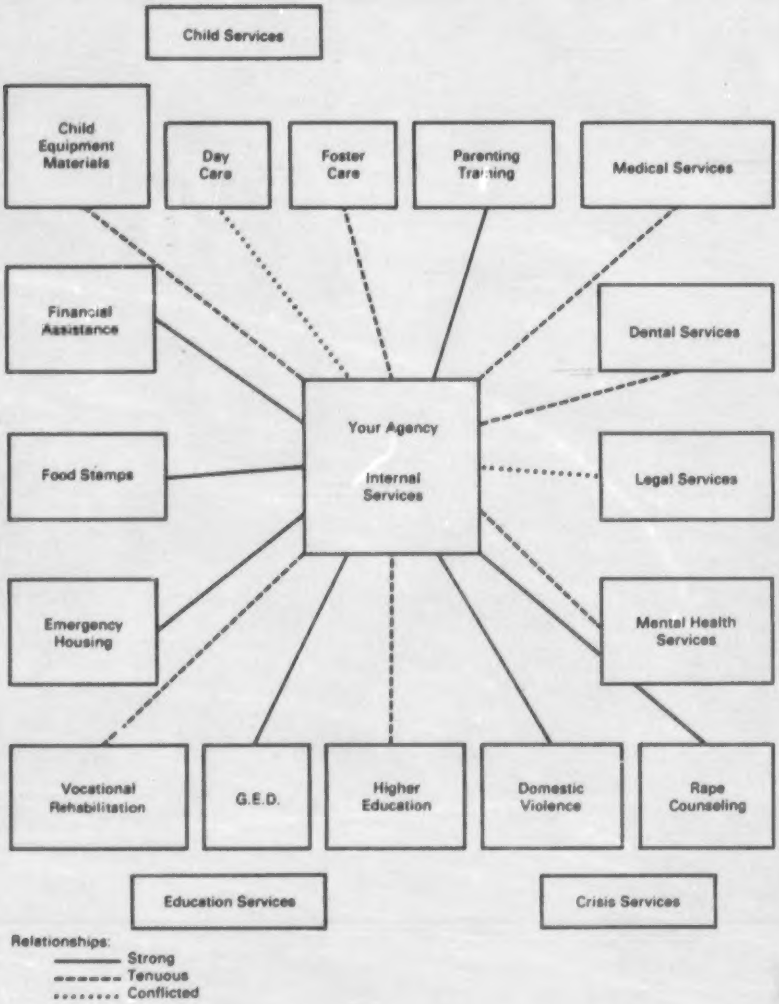
Child Services
Child Equipment Materials
Day Care
Foster Care
Parenting Training
Medical Services
Financial Assistance
Dental Services
Food Stamps
Your Agency
Internal Services
Legal Services
Emergency Housing
Mental Health Services
Vocational Rehabilitation
G.E.D.
Higher Education
Domestic Violence
Rape Counseling
Education Services
Crisis Services
Relationships:
Strong
Tenuous
Conflicted

FIGURE 3. Agency eco-map

needs. The needs of chemically dependent women have been identified in two large-scale research efforts. The Alliance (National Research and Communications Associates 1978) report provides summarized findings from all 50 States. Data produced by the Women's Drug Research Project (Reed and Leibson 1981) show similarities and differences among various subgroups of women, differentiated by ethnicity, geographical location, and other factors.

The following service needs were rated highest in the two studies:

- Health care, with specific attention to gynecological problems, venereal disease, birth control, and abortion;
- Health promotion and education;
- Educational counseling;
- Vocational training and job placement;
- Childcare;
- Sex education and sexuality counseling;
- Rape counseling;
- Marriage (or conjoint) counseling;
- Parenting skills training;
- Counseling for family members;
- Training to develop coping and survival skills;
- Legal assistance;
- Transportation;
- Financial (public) assistance; and
- Housing.

STEP 2: ASSESSING PROGRAM SERVICE RESOURCE CAPABILITY

After determining client needs, the treatment program must assess its own service delivery system to determine the appropriateness and quality of each service. It must also address the more fundamental question: To what extent do these services address the needs of chemically dependent women? A treatment program must be realistic and objective during this second step.

An instrument similar to the one shown in figure 4 will help programs assess their service delivery systems and establish criteria for judging the usefulness of resources.

Type of service required: ____________________

Resources required to provide this service (i.e., equipment, space, time, consumables, etc.): ____________________

Specific skills or knowledge required to deliver this service:
____

General goals or outcomes anticipated for clients using this service: ____________________

If this service has been provided, have these goals been met?
____

If not, why not? ____________________

If the service is provided, does the program have the resources listed above readily available? ____________________

If the service is provided, does the staff have the skills or knowledge listed above? ____________________

Cost factors:

Budget items	Cost
____________________	________
____________________	________
____________________	________
____________________	________
____________________	________

FIGURE 4. Assessment tool #2: service inventory

As an example of how this form might be used, we may suppose that a treatment program currently provides childcare services as a response to clients' needs. At this point in the process of network building, these services should be assessed. Using the form in figure 4 above might provide the information shown in figure 5.

Figure 5 shows that the goals of this particular service are only partially met and that there are problems in providing the service, namely the inability of the program to offer childcare services for clients participating in treatment activities away from the program site and the use of staff time to seek donations of consumables. (In the next section, we will review methods of comparing costs and benefits of different modes of service delivery.)

Type of service required: Childcare while mothers are in treatment activities at or away from the program site.

Resources required to provide this service: Large room, toys, cots for rest, art supplies, books, music, snacks; available 9:00 a.m. to 5:30 p.m.

Specific skills or knowledge required to deliver this service: Staff should have training/credentials in child development (minimally) and early childhood education (preferred).

General goals or outcomes anticipated for clients using this service: Program clients should be relieved of parenting responsibilities to freely participate in program and referral treatment and rehabilitation activities.

If this service has been provided, have these goals been met? Partially.

If not, why not? Licensing is required for services provided to children when mothers are not onsite. Toilet and kitchen facilities at the program do not meet licensing standards.

If the service is provided, does the program have the resources listed above readily available? Replacement of consumable supplies (art materials, snacks) depends on soliciting contributions.

If the service is provided, does the staff have the skills or knowledge listed above? The budget provides for a certified childcare worker, currently on staff.

FIGURE 5. Assessment tool #2
completed sample

Information such as that provided above should be obtained for each service identified in the client population needs assessment. Based on this information, the treatment program can objectively assess its service delivery. Results of this kind of inventory, however, are not easily separated into categories with labels such as "provided at program" or "provided through referral." The following method of categorizing services has been found to be helpful in assessing the availability and practicality of service delivery.

- Category 1: Service that can and should be provided by the program (e.g., family therapy or counseling at a program whose trained family therapist could incorporate knowledge of the client's chemical dependency into family treatment).

- Category 2: Service that can be provided by the program--skills and resources are available--but would be more appropriately provided through referral (e.g., childcare, if the increased noise and use of space and staff time present problems but the service is so important that it should be provided at the program if unavailable elsewhere). Such services might be given lower priority in the actual development of referral linkages.

- Category 3: The service cannot be provided by the program; skills and/or resources are unavailable (e.g., if a program does not have adequate funding to obtain the services of a lawyer, it cannot directly provide legal services or counseling). (Note that volunteer services, even if available at the program site, are considered in the present context to be referral services because setting up volunteer service delivery requires linkages.)

Charting the results of the categorical assessment helps to clarify the current and potential service delivery capability of a program. Figure 6 shows a possible representational design.

Service Needed	Category 1 Currently Provides	Category 2 Could Provide	Category 3 Cannot Provide
List services delineated in Step 1.			

FIGURE 6. Assessment tool #3

Services listed in category 1 would be those assessed according to the model presented in assessment tool #2 and found to be appropriate and effective services as provided by the treatment program.

Services listed in category 2 might include some services being delivered but found, when assessed, to have unattainable goals or to be ineffective as delivered by the treatment agency. The example of childcare services cited in figure 5 would be such a service. Category 2 services also might include needs expressed during the client needs assessment of step 1 of which the treatment program was unaware but which the program could provide. For example, the treatment program may have been unaware that many clients needed sex education, especially regarding birth control. The agency would have a choice--ask a staff member or consultant to give lectures and individual counseling on the topic, or refer clients requiring this service to a community resource such as Planned Parenthood. Thus, sex education would be listed in category 2. Factors influencing the determination of how to provide the service will be discussed under step 3.

The category 3 list would include all services needed by clients that cannot be provided by the treatment programs. For most treatment programs, this category would include foster care for clients' children, dental care, and financial assistance. The category 3 column then becomes the focus of network development. The category 3 list, however, will not be complete until the treatment program performs step 3 of the network development process.

STEP 3: EVALUATE REFERRAL VERSUS IN-HOUSE SERVICE DELIVERY

As services are reviewed, it may become apparent that many services fall into the second category--that is, the treatment program provides many services with less than complete effectiveness or does not provide the services but could. To provide comprehensive treatment, ultimately all services listed in category 2 must be moved to category 1 or category 3. In other words, treatment programs must choose, for all services delineated in the client needs assessment, whether to provide direct services or community linkages, if available. For each service, the decision should be based on a cost/benefit analysis.

Before analyzing costs versus benefits for specific services, it is important to understand the most significant cost/benefit issues affecting services in general. The general costs and benefits of providing services within a treatment program versus obtaining services via interagency exchanges or linkages are outlined in table 1. The issues outlined in this table will be explained in the following text.

The cost/benefit issues in table 1 can be grouped into three areas of concern: management issues, qualitative and quantitative service/resource issues, and client-related issues. Although some issues overlap broad areas (e.g., staff burnout is a management issue but also affects the quality of service delivery), for purposes of this chapter we will examine issues within the context of each of these broad areas.

Management Issues. Management issues include the use and allocation of program resources (funds, space, staff, consultants, and advisers) in the planning and development of program services congruent with program philosophy, policies, and priorities.

Staff time is an important program resource, and a management function is to use staff time in the most efficient and effective manner. In instances where staff skills are less than optimal (as determined by comparing actual skills to those listed in the

TABLE 1.--Cost/benefit table

Services	Benefits	Costs
Provided directly by program	Can directly monitor quality control Can provide consistency in philosophy and style of service deliveries Clients can receive multiple services in one setting --May attract more women into treatment --Less likely to lose the women during the referral process --Services more accessible with fewer auxiliary steps	Quality and quantity of services may not be adequate given number of staff and financial resources Staff time spent in direct service delivery so that necessary administrative and accountability tasks get insufficient priority Staff burn out because they are spread too thin and overwork themselves Clients can become overly dependent on the program Need high levels of funding that are likely to result in complicated reporting and accountability requirements
Obtained via linkages with other programs	Clients can learn skills and gain confidence in locating and obtaining needed services Clients can develop relationships with sources of services that will continue after termination from treatment	Prevents direct quality control of services Takes staff time and energy to develop and maintain linkages Clients may encounter negative attitudes in other settings

TABLE 1.--Cost/benefit table--Continued

Services	Benefits	Costs
	--Transition out of treatment will be less abrupt and recidivism less likely	Clients may not follow through on referrals and may not get services needed
	Can provide a wider range of services to clients	Administrative and coordination tasks necessary to maintain linkages are often perceived to be less satisfying by staff than direct one-to-one client contact
	In the process of developing and maintaining linkages, can educate the staff of other agencies about the needs of chemically dependent women --Increase referral --Decrease negative stereotypes and increase agencies' receptiveness to serving chemically dependent women --Useful public relations --Increase probability of agency survival	Obtaining followup information and effective coordination of service is more difficult (e.g., issues of communication across agencies)

service inventory) or where staff time is spread too thin, it may be wise to devote available time and energy to providing a good referral system for clients. Often, when a treatment program attempts to provide more services than are realistic, various problems emerge. One problem is staff burnout. A major cause of burnout is the setting of unrealistic goals by staff persons for themselves and their clients. Another potential problem is that staff will spend an increasing portion of their time providing direct services and neglect other important, albeit less personally rewarding, aspects of their jobs, such as recordkeeping and other activities related to compliance with Federal, State, and local funding sources and regulatory agencies.

Another important management issue concerns the control of philosophy and policy governing the delivery of services. A benefit obtained by a treatment program that provides services directly is that the program can control the context and content of the service as well as its relationship to other services. A program can be confident that its philosophy is reflected in services if those services are provided by staff persons who are accountable to and committed to the program. For example, a treatment program can be sure that vocational counseling is nonsexist in practice as well as in principle only if the treatment program can monitor covert as well as overt policy and practice--something difficult enough to do within the program and frequently almost impossible in referral and interagency relationships. For example, it is important to know whether women are steered toward traditional jobs and training, even though an agency's policy is nonsexist. Is the resource agency staff sensitive to the effect of the low self-esteem of addicted women on their stated job preferences? Later in the chapter we will discuss ways that treatment programs can build assurances, if not direct control, into referral agreements. At this stage of the network building process it is important to evaluate the relative importance of such factors for each service needed. In the example of vocational services stated above, philosophical and policy control might be deemed important benefits; in the case of other services, such as domestic violence crisis services, the question of philosophical disparity might be less important.

Use of funds is another management cost/benefit issue. Does the need for a particular service justify the amount of money necessary to provide the service? In a treatment facility serving women who do not have many dependent children, it does not make sense to pay for a full-time childcare worker.

Programs must also determine whether particular services are consistent with the goals and purposes of the funding source. Using "treatment dollars" for "supportive" or "ancillary" services by the funding source could jeopardize future funding of the treatment program. Using childcare as an example again, some funding sources might consider the salary for a childcare worker as paying for an indirect service, inconsistent with the intention of funding only direct treatment services. Thus, it is important that program managers clearly understand the limitations imposed by funding sources before making decisions regarding the provision of new services within the program.

Service/Resource Issues. Any time services are provided via interagency exchanges, the treatment program lacks direct quality control of service. This problem is often aggravated by difficulty in assessing the quality of services rendered by a referral agency. This occurs because treatment programs (and other referring agencies in general) often find that obtaining feedback and followup information from referral resources is a difficult, time-consuming, and frustrating task. Followup information and interagency communication are critical determinants of a successful referral network.

Early in this chapter, we stated that an individual operates within a larger environment with many independent and interdependent subsystems. Comprehensive treatment can occur only if the interdependence of subsystems and client needs within these subsystems is recognized and services are delivered congruently. If the primary treatment resource (i.e., the treatment program) does not know the specific plan for addressing a specific need and is not kept informed of client progress, it is possible that other services will be either misdirected or improperly handled. Accordingly, communication among providers is a cornerstone of a multiservice approach to treatment. Communication is most likely to occur when services are provided at one location. Staff meetings, case conferences, and informal channels of communication provide mechanisms for feedback and followup within a program. Such mechanisms are not routinely in place for interagency communication.

Often, even if procedures have been established, agency staff members do not use them on a regular basis. Thus, a potentially serious problem in service delivery can be avoided by providing the required service at the treatment program. Once again, however, there are ways to avoid or minimize this problem if linkages are properly developed. This aspect of network building will be discussed later in this chapter. The disadvantages related to communication when services are referred to other resources can be reduced, so that the advantages of followup and communication within a treatment program need not be given undue emphasis in deciding whether to provide a service.

Client-Related Issues. It is important also to assess the effects of internal versus referral services on the individuals being served. An advantage of direct services at the treatment program is accessibility. No additional services are required to facilitate use of the primary service. For example, if childcare is available at the treatment program site, the program site does not have to worry about providing or arranging for transportation for the client and her children to a childcare facility in the community. Transportation is often a difficult service to provide, and many examples can be cited in which available services were

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not used by the client population because they were simply inaccessible. The more services available in one location, the easier and therefore more likely it is for a client to avail herself of these services. Also, less time is spent moving from one location to another, which is a crucial factor for working mothers. Accessibility, however, can also interfere with clients' learning to function independently. Again, careful weighing of cost/benefit factors is necessary.

Another advantage to clients is familiarity with and a sense of security at the program. Counselors who have worked with chemically dependent women are aware of the fact that many women have had only negative interactions with community resources and in many cases have been discouraged rather than assisted. Clients may be reluctant to use resources, fearing stigmatization or mistreatment. Unfortunately, if clients are protected from such possibilities and are encouraged to rely on their safe and comfortable relationship with the treatment program, they fail to improve or develop important skills in problem solving and confronting new situations. The program and its staff might better serve clients by providing a support system that encourages greater use of community resources, despite the risks, and helps clients cope with deleterious or painful experiences. Here too, the advantage of providing services internally is counterbalanced by the clients' growing dependency on the treatment program. If the treatment program provides structured opportunities for clients to use community resources, several aspects of client growth can take place:

- Clients can gain knowledge of available community resources;
- Clients can enhance their self-confidence through successful use of resources; and
- Clients can learn appropriate behaviors for relating to resources.

As clients progress in treatment, the program should provide mechanisms to encourage their independence. The ability to maintain abstinence while living a productive, satisfying life must be achieved without complete dependence on the program. By helping clients become familiar with resources they may need to use after treatment, and by helping them learn how to approach and use these resources, the treatment program can best facilitate independent functioning. Of course, as we shall see later in this chapter, these benefits can be realized only if the treatment program appropriately structures the referrals.

Networking Benefits. So far we have examined management, service, and client-related cost/benefit issues in terms of providing services through a referral approach. Several important advantages, however, that do not directly relate to providing services can be gained from developing and maintaining a community resource network.

Pinder (1978) reminds us that many obstacles prevent open, meaningful encounters with chemically dependent women. Overcoming these obstacles requires health and social care workers to be familiar not only with issues of drug and alcohol dependency but also with women's issues.

By establishing linkages with health care and social service agencies in the community, a substance abuse treatment program can educate and sensitize workers to women's issues. The Alliance task force reports (National Research and Communications Associates 1978) identified a "general lack of awareness about the problems of women among all health professionals." The reports called for the development of training programs for health care providers, including physicians, nurses, counselors, psychologists, paramedics, and emergency room technicians. The reports also indicated that training curriculums for health professionals should include such topics as women's health, nutrition, and sexuality and sensitivity training in addition to assessment and intervention in chemical dependency problems. Although social service and health care providers appear to be cited as primary targets for such training, it is important to note that other groups should also be alerted to the problems of women in general and chemically dependent women in particular. These groups include the clergy, teachers, and those within the criminal justice system. Training, then, has several functions: to obtain better services for program clients, to identify potential clients, and to sensitize individuals to women's issues, needs, and problems.

In addition to the fact that substance misuse often goes undetected in traditional agencies, it has also been found that service providers often hold strong opinions about chemically dependent clients. Too often, referrals from drug abuse treatment programs are seen as "undesirable" or in some way incapable of profiting from the services offered. Many agencies view the chemically dependent client as disruptive, reluctant, unreliable, and generally not a good candidate for treatment. By establishing relationships with key people in the community resource, programs can dispel many myths through training and the development of good referral procedures.

Linkages with a range of service providers can generate a support system for a treatment program which is important for the ongoing development of the program. Organizational linkages can affect funding decisions, for example. Should a treatment program seek a grant to expand services or add a research or evaluation component, or any other activity, letters of support from the community are required, or at least enhance the justification for funding. If a treatment program works closely and harmoniously with other agencies, it is likely that the community will better understand and recognize the need for the treatment services provided. Other organizational advantages of network development include shared use (and, therefore, reduced expense) of equipment, consultants, and other resources. As needs develop within the community, linkages provide the basis for creating new and appropriate models of resource exchange. A number of exchange models will be discussed later in this chapter.

STEP 4: PREPARE COMMUNITY RESOURCE SURVEY

So far we have discussed the first three steps in developing a community resource network: (1) assessment of client needs, (2) assessment of treatment program service capability, and (3) evaluation of referral versus in-house service delivery. After completing steps 1 through 3, the treatment program will have generated a list of services to be sought from community resources. If staff time is limited, as it usually is, the list items should be ranked. High priority services should be those required by most clients as well as those needed to meet basic survival needs.

After this list is generated, the first step in network building can begin--identifying all available community resources for each service area. The complexity and difficulty of this task will vary considerably for different programs, with geographical location being a major factor. A second factor is the number and type of problems encountered. In large urban areas, for example, this step is often time consuming and complex because of the number and often specialized nature of community agencies.

Thus, depending on time available and the complexity of the community, staff members can focus on one or two needs at a time or can simultaneously gather information on the entire list of services. In any case, all potential resources must be identified and evaluated if the most appropriate services are to be selected; however, it is generally advisable to restrict linkages to a limited number of resources for each service area.

Sources of Community Resource Information. A variety of information sources are readily available regarding services and resources in most communities. Except in unusual circumstances, treatment programs should go to each available source. An important reason for doing this is to avoid using familiar resources without investigating other resources that may offer additional services or be more appropriate for certain clients. Following is a list of information sources that are accessible to most programs:

Internal staff. All staff members should be asked to identify resources that they have used for referrals or used themselves. For example, women staff members with children are likely to know about childcare facilities. In addition, the board of directors, advisory groups, and consultants to the program should also be surveyed. People are generally selected for these roles because of their knowledge of the community or their expertise in treating chemically dependent women.

Program clients. Although they may not have used the services, clients frequently know about resources in a community. If clients are involved in the networking process early on, they will probably be less resistant to later referrals.

Community service directories. An effort should be made to locate all available community service directories. In many areas, the United Way provides a directory (frequently annotated) of all public service agencies or all agencies receiving United Way funds. Although there is generally a charge for these directories, they are worth purchasing because they contain relevant information. Labor unions, crisis hotlines, and consumer groups also publish resource directories. Libraries frequently have such directories as reference materials.

Government agencies. Federal, State, and local government offices responsible for regulating and licensing particular types of facilities can generally provide lists of facilities that meet regulatory standards. Using childcare as an example, most governmental jurisdictions require that all day care and foster care facilities be inspected and approved. Names of approved facilities are usually made available to the public at no charge simply by calling or writing to the appropriate government office. Although licensing regulations rarely cover all areas of service delivery (in childcare facilities, this could mean that physical aspects of the facility are regulated, whereas program content is not), licensing agency directories at least provide a comprehensive list of facilities that meet certain minimum standards. Treatment program staff can choose from this list the most qualified and appropriate agencies for developing linkages. This can be done, as the next section explains, by evaluating each agency in terms of additional characteristics found to be important to treatment staff and clients.

Telephone directories. The yellow pages of local telephone directories can also provide listings of resources in several areas, including childcare, legal services, medical services, vocational training, and job placement services. Resources identified in this way, however, are likely to require thorough investigation because there are no certifications or standardized requirements for telephone directory listings.

Referral services. Local (county or State) bar associations and medical societies can provide names of individual and agency resources within specific geographical locations. Once names are obtained, however, the treatment staff will have to assess such factors as attitudes toward women and substance misuse. Agencies such as the Better Business Bureau, other local business associations, consumer groups, and professional organizations frequently compile referral listings.

Women's organizations. Local chapters of groups such as the National Organization for Women and medical, legal, and other service providers with a sensitivity to women's needs are often able to recommend resources for services such as rape counseling and domestic violence shelters. Further assessment by the treatment program staff is somewhat easier for resources identified in this way, because only attitudes toward and knowledge about chemical dependency would need to be assessed.

Substance abuse treatment programs. Other programs serving chemically dependent persons in the area may have already established community linkages for services. Although there is often a competitive (and sometimes overtly or covertly hostile) relationship among treatment programs as a result of differences in treatment philosophy, funding competition, or client competition, there is rarely any realistic benefit to perpetuation of ill will among treatment programs. Important benefits can be derived from cooperation and shared efforts, however, particularly in the area of community resource networking. A coalition of treatment programs can often effect change that could not be accomplished by a single program. Thus, if at all feasible, a treatment program should share resources and participate in network building with other substance abuse programs. The effort used to call for an interagency task force to assess and establish linkages with community resources might be less than that needed to develop a network and would provide the secondary benefit of a support system among treatment programs.

STEP 5: ASSESS COMMUNITY RESOURCES

After all potential referral sources have been identified, the next step in network building is to identify resources that are appropriate service providers for the client population and that are also interested in working to develop viable linkages.

To accomplish this step, the treatment program must develop a standardized mechanism for assessing and evaluating resources. The easiest way to do this is to construct an assessment instrument that can be completed for each possible resource in a network. The form should be as brief as possible yet include items about each aspect of service delivery relevant to the treatment program and its clients. In addition to specific information about the services offered, other important information includes admission and eligibility requirements, data on the population served by the resource in the past (client profiles), costs and fees, and the resource's willingness to establish communication mechanisms with the treatment program.

Questions on the assessment form should be as objective as possible. For example, it is better to ask about the attrition (dropout) rate for women served by an agency than to ask if the agency is sensitive to women's needs. The first question is less confrontational and provides equally useful data because the assumption can be made that a high attrition rate will occur if a resource or agency is not sensitive to women's needs. By asking questions about client profiles, a program can assess the appropriateness of the resource for chemically dependent women. A sample form for community resource assessment is shown in figure 7.

The form shown in figure 7 is meant to serve only as a general model, since differences in client demographics, geographic location, and other program characteristics would dictate variations. For example, questions relating to public transportation might have little significance in a rural community, where public transportation is not available at all.

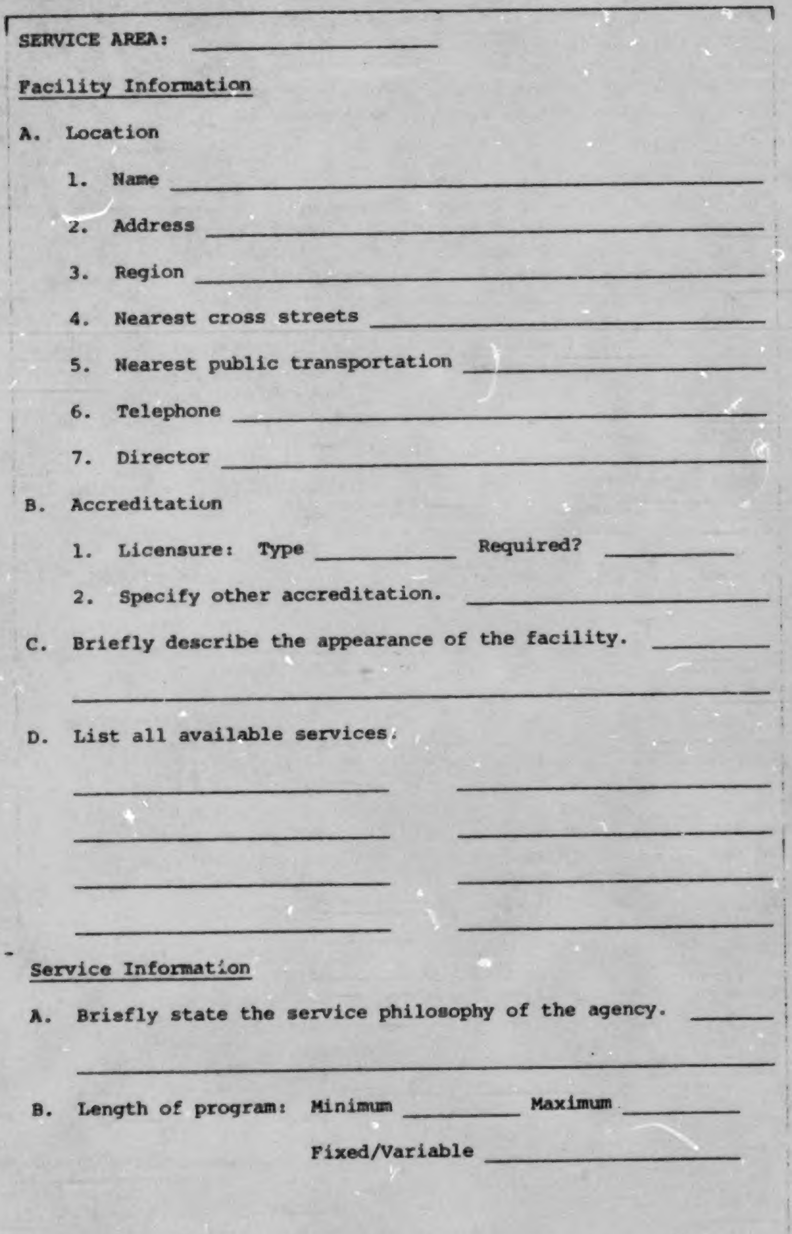
Before adopting an instrument, the program staff should field test the form on one or two resources, preferably resources with which the treatment program has had some experience, to determine whether the items included actually produced the data needed for selection of resources.

In developing and using assessment instruments, it is important to know which characteristics of the resources are critical variables in selecting resources. One way to determine the characteristics to look for in potential resource agencies is to ask clients in your treatment program which agencies they have had contact with and what they liked and disliked about each. Some client populations may have had experience in relating only to "survival resources"--for example, welfare and emergency medical services. Women staff members might, in such instances, be asked to describe their experiences with community resources in terms of good or bad aspects of services. This type of feedback is important not only in selecting resources for a network, but in assessing and updating a community resource network.

After identifying critical variables, designing an assessment instrument, and completing an objective assessment for each identified resource in a particular service area, the program should evaluate and compare resources in terms of their relative capability to deliver services to the client population.

Although the methodology described thus far appears to be straightforward, several problems can, and often do, arise in the process of selecting community resources for linkage development. Some of the most common are the following:

Unavailable Services. The unavailability of particular services may surface at three points: when information is being gathered about the resources in a community, when the onsite evaluation of a resource is performed, or when a referral is made. In the first instance, it becomes apparent that a needed service is not provided in the community. On a short-term basis, little can be done in such cases. As noted by the National Polydrug Collaborative Project (Wesson et al. 1978), the following long-term steps can be taken:



SERVICE AREA: ____________

Facility Information

A. Location

1. Name ____________

2. Address ____________

3. Region ____________

4. Nearest cross streets ____________

5. Nearest public transportation ____________

6. Telephone ____________

7. Director ____________

B. Accreditation

1. Licensure: Type ________ Required? ________

2. Specify other accreditation. ____________

C. Briefly describe the appearance of the facility. ________

____

D. List all available services.

____________ ____________

____________ ____________

____________ ____________

____________ ____________

Service Information

A. Briefly state the service philosophy of the agency. ______

____

B. Length of program: Minimum ________ Maximum ________

Fixed/Variable ____________

FIGURE 7. Community resource assessment form

Admission and Referral Information

A. Describe the established procedure for making referrals.

____

____

B. Contact person: __________________ Phone: ________

C. May clients be referred to a specific staff person? ______

____

D. Can an appointment be made at the time of the referring phone call? ______________________

E. What is the maximum waiting period for:

An intake appointment ______ Program participation ______

Eligibility Requirements

A. Are there any specific limitations for service eligibility re:

Age ________________________________

Catchment area ______________________

Legal/criminal status __________________

Drug use ___________________________

Medical problems _____________________

Psychiatric problems ___________________

Sex/sexual preference __________________

Educational status ____________________

Income level/source of income ___________

B. Describe the typical client profile:

Age ____ Race ____ Sex ____ Socioeconomic level ____

Substance abuse history _________________

Psychiatric history ____________________

FIGURE 7. Community resource assessment form, continued

Employment status ______________ Marital status ___________

Referral source ____

C. What percentage of clients are women? _______________

D. What is the attrition rate? All clients _____ Women _______

Relationship With Referring Treatment Program

A. Can the agency provide the following communications?

1. Monthly followup reports ___________________________

2. Communication with the treatment program prior to changes in the client's status--i.e., termination, program completion, secondary referral, etc. ___________

Costs and Fees

A. Does the agency have fees for services? _______________

B. If so, what is the fee policy for indigent clients? _______

____

C. How are clients informed of fees and payments? __________

____

D. What are the sources of the agency's funding? ___________

____

Assessment (by treatment program staff)

A. Which clients are most likely to benefit from services? ___

____

B. What are agency strengths? ____________________________

C. What are agency weaknesses? ___________________________

FIGURE 7. Community resource assessment form, continued

- Join with other community groups to lobby for such programs.

- Express concern about the absence of such services to local, State, and Federal substance abuse funding, coordinating, and regulatory bodies.

- Consider submitting proposals for additional funding to provide these services in your program or in a consortium of programs.

- Attempt to create the services locally, by changing eligibility criteria used in existing programs or by encouraging modification of existing resources.

Except in rural areas, it is unlikely that a vital service or resource is nonexistent. More often, a service is "unavailable" during or after the assessment of agencies. Although services may be available in principle, they are not easily accessible to program clients. This may be because of insufficient resources to meet demands, necessitating long waiting periods for potential recipients. Even more frustrating, however, is exclusion of clients from resources because of biases against persons with histories of addiction or against women.

An example of this bias occurred in a large metropolitan area, noted for its comprehensive network of substance abuse and supportive service agencies. Through a Federal grant, a methadone program was established in a large general hospital. As the program developed, it became increasingly evident that within the hospital there was strong resistance to providing necessary supportive services to clients in the methadone program. Women in the program seemed particularly affected by the hospital policy, since the women in treatment tended to have a greater array of problems, particularly medical problems.

What can be done when there is evidence that an agency has a bias against women or chemically dependent clients? If alternative resources offering comparable services are available, it is possible to simply avoid including the offending agency in a referral network. When alternatives are not available, one option is to offer training to the agency to facilitate changes in values and attitudes. If the resource agency is unwilling to accept training, then the treatment program must revert to using the options noted above. In cases where bias makes services unavailable, the treatment program should strongly voice concerns to appropriate funding and regulatory agencies.

Even in agencies where policy does not reflect these biases, the program should assess practices of the community resource. One way to do this is to request information regarding outcomes of previous clients at the agency. In the case of vocational rehabilitation services, for example, the treatment program should request data regarding specific jobs and training offered to female clients seen during the preceding year. This information should tell the treatment staff whether the community resource's policies and practices are consistent. If a disparity is found, training should be offered to agency personnel. Finding bias in practices should be seen not as a barrier but as a potentially correctable weakness. Further, training offered and accepted will not only improve the resource but will make the agency more responsive to the needs of women clients in general. (Training goals and methods will be discussed later in this chapter.)

The evaluation of community resources is a critical step in developing a resource exchange network. If an agency's service capabilities and its willingness to provide referral services are not carefully and accurately assessed, referrals will be haphazard and of poor quality.

STEP 6: DEVELOP EXCHANGE RELATIONSHIPS

The final step in the process of developing linkages for chemically dependent women is to develop resource exchange relationships with community resources selected using earlier steps in the process.

Communication and Information Exchange. The most important elements in interagency relationships are good communication and information exchange. Communication must be clear in the following areas:

Expectations of the treatment program. The treatment program should clearly understand the nature and magnitude of services, eligibility requirements, and client outcome goals at each resource and should not expect a resource to deviate from those services, requirements, or goals. As an exchange relationship develops, treatment program input, consultation, and training may influence a resource to change any one of these aspects of service delivery. At any point, treatment program expectations must be based on what is available at that time. It is, in other words, important to differentiate between current realistic expectations and strategies for change.

Referral information. The treatment program must consistently provide the community resource with whatever information the resource requires for admission and adequate service provision. Honesty is critical for establishing and maintaining referral relationships. Attempting to fool a resource agency about a client's qualifications or problems may destroy the relationship. Further, by being honest about clients' status and referring only appropriate clients for services, the treatment program can help change negative stereotypes of the client population.

Of course, client information can be shared with community resources only with the informed consent of the client. The client should be aware of the type of information to be disclosed, the reason for its disclosure, and the agency receiving the information.

Client followup. This is often thought to be the most critical determinant of the effectiveness of referral services. The treatment program must take responsibility for coordinating services, maintaining continuity of care, and resolving problems that arise in the referral process or during utilization of referral services. Arrangements with resource agencies for followup must be clearly understood and mutually accepted.

Several mechanisms are available for followup. Depending on the nature of the referral service and the agreement with the community resource, one or more mechanisms might be used.

1. Case conferences. Face-to-face conferences between treatment program staff and community resource staff provide an opportunity to discuss problems with specific clients, possible corrective responses, and interagency problems or policy issues that surface as a result of interaction regarding a specific client. Case conferences, however, are the most time-consuming way to obtain feedback and should be used only when necessary. Conferences are useful when the treatment plan is complex and multiple agencies are involved. A case conference can eliminate or resolve conflicting demands or requirements for the client, in addition to allowing for an exchange of information about the client and her needs; this can facilitate a cooperative relationship among the agencies involved. Case conferences are also helpful when the client has problems in using the referral services. Again, sharing information can help pinpoint the cause of the problem--for example, inappropriate referral, lack of client motivation or readiness, and overt or covert negative resource attitudes toward the client--and can use the group process to decide on corrective actions.

   On an organizational level, staff interaction during case conferences can promote better understanding of other agency roles and strengthen organizational support systems.

2. Followup forms. Written followup information is generally a quick way to obtain feedback about client participation in referral resource activities. These forms also provide records of client involvement in activities and services called for in treatment plans. Generally, when the treatment program wants written followup communication, it should provide the community resources with a clear rationale for the importance to both agencies as well as a simple, short format for providing information. Almost without exception, staff members in service agencies feel overburdened with paperwork

and resent any additional reporting or recordkeeping. To obtain the cooperation of resource agency staff in providing the necessary information, the treatment program must assure resource staff that treatment staff will use the information for problem resolution and case management. Keep in mind that we are discussing resource exchange relationships, and exchange indicates that each party will provide something to the other party. If the resource provides services and information, the treatment program must provide a response to that service or information.

The form shown in figure 8 is a model for a followup form that might be provided to resource agency staff. A checklist rather than a narrative report is generally preferable, for two reasons. First, it reduces the time needed by resource staff to provide the necessary information, and, second, it provides consistent information which can be used for comparison and evaluation.

Client name or ID# ______________ Period covered by form _______

Referral agency _________________ Contact person _______________

Attendance/participation:

___ Excellent
___ Good
___ Needs improvement
___ Poor
___ No participation

Progress:

Poor 1 2 3 4 5 Excellent (Circle one)

Recommendations:

___ Continue with present plan
___ Motivate for participation
___ Needs additional services (specify) ________________________
___ Terminated for lack of interest
___ Terminated--inappropriate referral
___ Other (specify) ____

Comments: ____

FIGURE 8. Client referral followup form

The treatment program and the referral resource should agree on the frequency of followup reports. Factors influencing this decision include projected period of client involvement with the resource, possibility of immediate crisis intervention by treatment staff, and relationship of the service to other components of the treatment plan (i.e., is the service needed to facilitate or provide eligibility for other services?). In general, monthly followup reports are adequate from resources providing relatively long-term services; special reports can be made if a problem occurs that requires immediate action by treatment staff.

The treatment program also must agree to provide the resource with any feedback information requested (with client consent, of course), keeping in mind that only the original treatment program is in a position to coordinate and, when necessary, relate information from one referral resource to another. For example, if a client is sent concurrently for medical treatment and vocational rehabilitation and is found to have a medical condition that limits her ability to perform certain types of work, the treatment program must make sure that the vocational rehabilitation agency is aware of these limitations.

3. Relationships with contact persons. Regardless of whether information is communicated in case conferences, written followup reports, or by informal telephone contact, a key ingredient in good resource exchange relationships is person-to-person rapport with someone within the community resource. The contact person or persons should be identified to treatment program staff, and all treatment staff involved in the referral process should get to know the person or persons individually. The contact relationship may be based on a formal relationship established administratively, or it may develop out of an informal rapport or friendship between members of both staffs. In either case, a good relationship is of great value to the communication process.

Treatment Program Recordkeeping. Another factor affecting the quality of referral relationships and therefore the effectiveness of referral services is the quality of the recordkeeping at the treatment program.

Treatment plans. Although the development of treatment plans is not within the scope of this chapter, the use of referral resources is determined by each client's treatment plan. If treatment plans are carefully developed, the information needed by the community resource should be readily available. Also, a good treatment plan will avoid conflicting referrals by clearly stating which facilitating or prerequisite resources must be obtained in proper sequence. It will be clear that referrals are time-appropriate as well as need-appropriate. The term "time-appropriate" is used to indicate that although a client may have a particular need, providing the resources to address that need may be useless unless other needs have been addressed first. If a client is unable, for example, to interact with people because of embarrassment and a poor self-image as a result of severe and disfiguring dental problems, referring her to a job placement agency before obtaining dental services would probably not have a successful outcome.

Referral records. For several reasons, it is important to keep records of each referral for each client. The first reason is to record progress in meeting the client's needs. The second reason is for ongoing assessment of community resources and the referral process itself. By compiling data from referral records, the treatment program can assess its own ability to select and use referral resources, as well as note the problems encountered with the resources. One such form was designed by Women's Center, an outpatient treatment program for chemically dependent women in Detroit. A form derived from the Women's Center form is shown in figure 9.

Composite data from a form such as the one shown provide information needed to evaluate the effectiveness of referrals. The individual form for a client provides data for changing a treatment plan or resolving referral problems. The treatment program staff should complete a referral form for each referral after the initial referral appointment and again when services are completed or discontinued for any reason.

APPROACHING COMMUNITY RESOURCES

To avoid unsuccessful exchanges, the treatment program must clearly understand the importance of communication, information exchanges, and recordkeeping before approaching community resources. Once treatment staff have proceeded to this point, they should approach community resources.

In most cases, the treatment program director or administrator should make the initial contact with a community resource to establish an interagency exchange. The treatment program director should meet with the community resource director or his or her designee to discuss ways that the agencies can work cooperatively. The meeting should be between directors because referral agreements involve policy-level decisions that cannot be made by staff persons. (Only informal referral agreements can be made without policy decisions, and the benefits and costs of this type of arrangement will be discussed in the following section.) It is important to approach the resources to discuss exchanges, rather than merely to request services, so that both agencies see some benefits in an exchange agreement.

I. REFERRAL

A. Client name or ID# ______________________________

B. Referring staff ______________________________

C. Referral agency ______________________________

D. Address ______________________________

E. Telephone ______________________________

F. Contact person ______________________________

G. Date of referral ______________________________

Date of appointment ______________________________

H. Referral type:

___ Clothing
___ Financial
___ Dental
___ Education
___ Housing
___ Childcare
___ Vocational
___ Medical
___ Mental health
___ Social service (specify type) ________________
___ Other (specify) ______________________________

II. OUTCOME

A. Client did not receive service because (check all appropriate):

___ Client did not keep appointment
___ Client was late for appointment
___ Client did not meet eligibility requirements (specify) ______________________________
___ Client declined further services
___ Referral agency inappropriate for services needed
___ Other (specify) ______________________________

B. Client received service:

___ Requires no further service
___ Requires further service, same agency
___ Requires further service, different agency

III. COMMENTS

FIGURE 9. Client referral form

Lauffer et al. (1977) point out that developing relationships among elements (i.e., community resources) in the environment involves consideration of the types of influence desired by the participating resources, or elements. Power may be defined as the ability to exert influence. Thus, if a treatment program wants to exert influence (e.g., convince the resource to provide services), it must examine its power. Individuals and agencies all possess and use power of one type or another. The kind of power most likely to be used by a treatment program is "reward power," described by Lauffer et al. as "the ability to make someone feel good because you can give them something for something they have done. Good publicity, letters of thanks, referrals, volunteer help are all examples of potential reward power."

Remember that we have been discussing exchange relationships. The treatment program can give the resource something (referrals, consultations, training) for something they have done (made services available). This is the power held by the treatment program. The "reward" will be different for different resources. By assessing resources, the treatment program should be able to determine the reward it can offer for services from that resource. For example, some agencies must provide services to a specified number of clients within a certain period in order to continue receiving funding. The treatment program has reward power if it can assure the agency of referrals that will help meet its required client population goal. In other cases, agencies are reimbursed for services delivered. If an insufficient number of clients request services, the agency may not receive enough funding to continue operation. Again, if the treatment program can provide clients for the community resource, the resource can maintain a funding base. Other agencies might have funding requirements to serve particular populations but lack the expertise to provide adequate services. In these instances, the treatment program might provide a reward in the form of training or consultation. Despite the nature of the reward, community resources should be approached on the basis of mutual benefit.

TYPES OF REFERRAL AGREEMENTS

Depending on the needs of both the treatment program and the community resource, and on the power relationship between them, different kinds of agreements may be reached. Table 2 outlines the various agreements and the costs and benefits of each.

For high-priority services or services that are difficult to obtain, the treatment program may choose to enter into a contractual arrangement to assure the availability of services when needed. For services not frequently needed, a formal or informal referral agreement is probably more appropriate. A referral agreement also works well when competition exists among community resources providing the same service. In these cases, the resources are likely to comply with treatment program needs without a contract so that they can obtain more referrals. In other words, when service

TABLE 2.--Types of agreements: cost/benefit table

Agreement	Benefits	Costs
Contractual arrangement	Assurance of service provision Followup and feedback mechanisms can be part of contract Staff time conserved in seeking resources	Loss of autonomy in contract assurances (e.g., may agree to refer all clients with a specific need to one resource) Difficult to change relationship if needs change or problems develop May be "locked into" provider
Jointly sponsored program (coalition)	Assurance of service provision Shared control of services, eligibility requirements, policy, etc. Followup easier to obtain	Loss of autonomy--both agencies must accept compromise Use of treatment staff time to develop service program May require use of other resources
Formal referral agreement	Not "locked into" one provider Greater flexibilty in referral choices	Less assurance of service provision (more competition) May not have control over followup, feedback
Informal referral agreement	No formal commitment to service provider--maximum flexibility Easy to stop referrals in services that are inadequate	No assurance of service provision No assurance of followup or feedback

providers compete for clients, the treatment program controlling the referrals has the greatest amount of power and can give up the least autonomy. Of course, the opposite situation is also true. When the demand for a particular service is greater than its availability, the treatment program has the least power and should attempt to assure the availability of services, even if autonomy is lost. Jointly sponsored programs require the greatest amount of treatment staff time and effort, and in some cases treatment program financial resources, and are best used when the program must provide unavailable services.

Initially, programs should select a limited number of resources to be used for referral in any service area. If a program uses too many resources, it is unlikely that a sizable number of clients would be referred to any one resource. Unless a resource feels that it will receive enough referrals, it may be reluctant to commit to an exchange relationship. Furthermore, the treatment program will find it difficult to formalize referral followup and feedback procedures as well as to continue ongoing evaluation of resources. When needs change or resources are inadequate, new exchange relationships can be developed.

INTERAGENCY TRAINING

In the discussion of advantages of resource linkages, it was noted that networking provides an opportunity to train and sensitize other community resources to the needs of chemically dependent women, particularly in agencies whose formal policy reflects theoretical bias against women and substance abusers. Further, health and social service care providers are often unaware of symptoms and indicators of substance abuse and dependency among women. Training by the treatment agency provides an opportunity to sensitize the resource agency staff to the need to refer their primary clients to treatment for chemical dependency if indicated. Resource agency staff should be trained to look for symptoms such as the following:

- Frequent mood swings;
- Drowsiness, inability to concentrate or focus attention;
- Complaints about gynecological problems, particularly menstrual dysfunction;
- Unstable marital or conjoint relationships;
- Problems with their children;
- Asocial behavior;
- Frequent absenteeism, if employed or in school; or
- Erratic childrearing practices.

This list of symptoms is not exhaustive but is provided to help treatment staff develop an idea of the level at which training must be initiated.

The treatment program, then, may find it necessary to present theoretical alternatives to agencies in addition to education regarding substance abuse and chemical dependency. This kind of training is difficult but is an important component of resource exchange networks. The task can be made easier by using available training materials, such as the National Drug Abuse Center's course designed to help people improve the services they provide to chemically dependent women. The course is titled "Women in Treatment, Issues and Approaches" and covers areas such as attitudes toward women, characteristics of addicted women, and effective treatment methodologies for women. Although the course is designed to run for 5 days, selected portions can be presented in shorter training sessions. The course can be purchased for a minimal cost from the National Drug Abuse Center, Box 398, McLean, Va. 22101.

PREPARING CLIENTS FOR REFERRAL

An earlier section discussed advantages of community linkages, including development of client independence from the treatment program. Clients must be prepared and trained, however, to use community resources effectively. Training should include ways of locating services and advice on using those services. Some methods that might be used for client training include didactic lecture, role playing, team or buddy systems, and "advocate apprenticeship."

Role playing, or behavior rehearsal, is a technique that requires individuals to act out relevant interpersonal interactions. A client is asked to pretend to be in an interpersonal situation involving a resource person; another client or staff person plays the part of the resource person. If the client's interaction with the resource person is inadequate or inappropriate, the staff person takes corrective action. Continued role playing will help the client learn and feel comfortable with new, more appropriate behaviors. Role playing can be used to help clients learn skills that will be helpful both in using referral resources and in locating and using resources after leaving the treatment program. Role playing can develop:

- Interviewee skills--how to explain needs and request services; and

- Information-gathering skills--how to ask the right questions about services offered, eligibility requirements, transportation possibilities, and other needed facts.

Modeling is a technique in which the client is exposed to one or more individuals (staff members or more advanced clients) who demonstrate behaviors to be adopted by the client. Treatment staff can model the appropriate behaviors, for example, in advocate or facilitator roles. The staff member might accompany a client to one or several community resources to facilitate the referral, instructing the client to watch the staff person's behavior. Later, the client could practice the appropriate behaviors in role playing sessions and eventually facilitate her own referrals or those of another, less experienced client. This process describes an "advocate apprenticeship," wherein the client learns new behaviors by "being apprencticed to" an individual already possessing the skills.

Didactic lectures are most suitable for helping clients learn skills that do not require interpersonal interaction. This method is useful for teaching clients how to dress appropriately for different activities, how to use resource directories, and how to assess the appropriateness of services.

DEVELOPING A RESOURCE DIRECTORY

Once the process of developing resource exchange relationships has been completed and staff and clients are prepared to implement referrals, the program should be sure that information about the various community resources is readily available. Relevant information from the community resource assessment form (figure 7) should be compiled by service category (e.g., childcare, vocational rehabilitation, domestic violence) in a community resource directory.

The directory should provide program staff and clients with the following kinds of information:

- Agencies available for specific services;
- Eligibility requirements for each agency;
- Specific services the agency provides;
- Profile of the typical client served by the agency; and
- Treatment program clients most likely to benefit from the services.

The directory should be updated as new linkages develop and old relationships change.

STAFF ROLES AND MODELS

Having discussed ways to identify appropriate community resources and the components of effective resource exchange relationships, we now need to look at persons responsible within the treatment program for network development and referral implementation. Resource exchange relationships may be developed through a collective staff effort, by a staff person serving as a community resource liaison for all services, or by one or more staff persons with expertise in one or more service areas who serve as referral/resource specialists for a particular service area. Various staffing patterns are also possible for implementing referrals by using primary counselors, a community resource liaison, or referral/resource specialists. The possible patterns are outlined in table 3.

TABLE 3.--Treatment program staff patterns: referral linkages

Model	Network Development Responsibility	Referral Responsibility
A	Community resource liaison	Community resource liaison
B	Primary counselors (administrative coordinator)	Primary counselors (administrative coordinator)
C	Community resource liaison	Referral/resource specialist
D	Community resource liaison	Primary counselors
E	Primary counselors	Referral/resource specialist
F	Referral/resource specialist	Referral/resource specialist
G	Referral/resource specialist	Primary counselors

A community resource liaison may be defined as a person responsible for understanding, developing, and using the network process, whereas a referral resource specialist would have expertise in the referral process and resource content for a specific service area. Primary counselors may also serve as specialists for a referral area.

In selecting a staffing pattern for network development and referral implementation, program staff should consider the following questions:

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- Does the size (i.e., number of treatment slots) and budget of the treatment program warrant a staff designation as liaison or specialist? The larger the program, the greater the need for a liaison person or coordinator because communication within the program is more likely to break down as the size of the staff increases. Also, the program is more likely to select formal rather than informal referral agreements, and the process needs to be structured so that the resource is not confused by different messages from different treatment program staff persons. In all but the smallest treatment programs, therefore, even if all primary counselors share responsibility for network development and referrals, one person should be responsible for administrative coordination to avoid duplication of efforts, gaps in the process, and mixed messages to resources.

- How complex is the potential resource network in a particular community? This can be determined during step 4 of the network development process, when resources are identified. Specialists and liaisons are more important when several resources will be involved in the network.

- Are primary counselors able to take on additional responsibilities? (How heavy are caseloads, other assignments, etc.?) Keep in mind the problem of burnout.

- Do primary counselors have the appropriate skills to train community resources and evaluate the outcomes of referrals? If not, the staff will need training or a new staff or consultant position will be required.

If the treatment program chooses a model using a liaison or specialist for referral implementation, all referral and followup information must be related to the primary counselor, who continues to have basic responsibility for implementing the treatment plan. Therefore, programs should not use a model that excludes the primary counselor from the referral process, although the process can work well if someone other than the primary counselor selects and makes the referral. Figure 10 graphically shows models for client referral.

Specific techniques for network development or referral implementation do not vary significantly when different internal staffing patterns are used. The most important difference involves communication within the program.

CONCLUSION

This chapter has outlined the steps necessary for developing and managing referral linkages for chemically dependent women. Treatment programs must decide which services are needed by clients, which services can be delivered, where to obtain services that

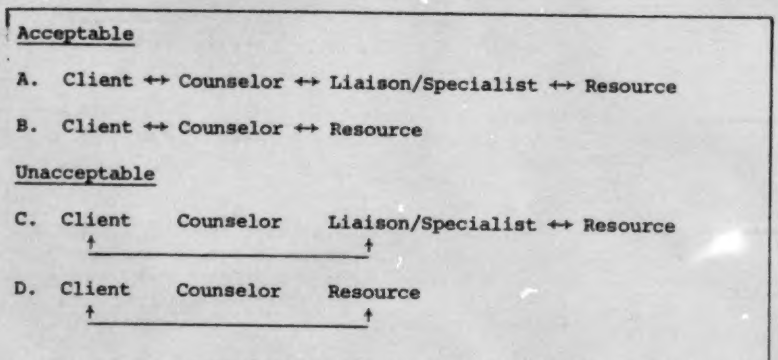
Acceptable
A. Client ↔ Counselor ↔ Liaison/Specialist ↔ Resource
B. Client ↔ Counselor ↔ Resource
Unacceptable
C. Client Counselor Liaison/Specialist ↔ Resource
D. Client Counselor Resource

FIGURE 10. Client referral models

cannot be provided within the program, what kind of referral relationships to arrange, and which staffing pattern is most suited to the program. In addition, assessment tools and reporting forms must be selected and/or designed. The process is complex, and programs should allow enough time to complete each step. Most important, remember that developing and managing a resource exchange network is a continuous, fluid process. Client needs change and must be periodically reassessed. Community resources also change, in terms of the scope of services, the target population, and the effectiveness of service delivery; ongoing evaluation will be necessary. The program itself will change, too, and those changes must be considered when evaluating the referral system. Keeping these factors in mind should make developing and managing referral networks a rewarding and helpful process for the program and its clients.

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6.

Medical Services for Drug Dependent Women

Josette Mondanaro, M.D.

MEDICAL PROBLEMS OF THE DRUG DEPENDENT WOMAN

Studies show that chemically dependent women, more often than men, enter treatment because of medical complaints, and that these conditions often go undiagnosed; if diagnosed, these conditions often remain untreated (Andersen 1977; Beschner and Thompson 1981). There is also growing evidence that programs simply do not have the knowledge or resources to address the multiple medical problems presented by chemically dependent women. Frequently, such needs are unrecognized or unresolved as counselors help clients cope with and resolve other problems related to drug use.

Brown et al. (1971) reported that 27 percent of drug-dependent women cited drug-related physical problems as the reason for entering treatment compared with 19 percent of drug-abusing men. In addition, 50 percent of the women in their study (compared with 22 percent of the men) reported that drug-related physical problems were the reason for their first withdrawal. In another study involving drug clients in Philadelphia, physical health was considered to be the primary reason for entry into treatment by 69 percent of the female drug abusers but only 31 percent of the male addicts (Flaherty et al. 1978).

Wilson and McCreary (1976) reported that the addict lifestyle is characterized by neglect of normal hygiene, health care, and nutrition. Based on a review of studies that examine medical problems, Dickey and Sowder (in press) found that infection, anemia, venereal disease, hepatitis, preeclampsia, hypertension, and diabetes were the most prevalent medical disorders for addicted women.

Prostitution, which is viewed as more prevalent among drug-abusing women than among nonabusers, may increase the probability of physical pathology, especially infection of the gynecological and urinary systems. Several researchers (Gossop et al. 1974; Santen et al. 1975; and Stoffer 1968) concluded that drug-abusing women are at greater risk for cervical and uterine malignancies as well as other gynecological problems, including an increased frequency of dysmenorrhea (painful menstrual periods).

Studies of drug-abusing women also indicate the need for birth control services. Stryker (1979) reported that 30 percent of former clients in the Hutzel Hospital Pregnant Addict Program were returning for their second or third unplanned pregnancy. In a study of prostitutes who abused drugs, James (1979) found that 46 percent failed to use contraceptive devices.

In studying the medical problems of women and men in 10 drug treatment programs, Andersen (1977) learned that women had more problems than did men in the genitourinary and circulatory systems. The research also showed that although women had more medical problems, they typically received inadequate physical exams at intake. [illegible] though 43 percent of the women had problems with their reproductive systems at initial intake, gynecological exams usually were not performed.

Medical complications continue to be a major problem for women clients after they are enrolled in drug treatment programs. Fifty-six percent of the women studied by Andersen (1977) developed gynecological problems while in treatment. Most of the medical problems (especially gynecological) reported for women clients went undetected at intake. Efforts were made to treat only 36 percent of the medical problems that were diagnosed (Andersen 1977).

Numerous medical problems were reported in a large sample of women treated in a pregnant addict program in Detroit (Stryker 1979). For example, 81 percent of the women clients developed vaginitis and 61 percent developed anemia during treatment. In addition, abnormal cervical Pap tests were recorded for 24 percent of the study subjects.

The high percentage of abnormal Pap tests indicates that many chemically dependent women are at high risk to develop cervical cancer (see chapter 7, this volume). The chances of developing cervical cancer are greater for women who have been prostitutes or who began sexual activities at an early age (Stewart 1979).

PREGNANCY

Many investigators have found that amenorrhea (lack of periods) and menstrual irregularity are common occurrences among addicted women (Finnegan 1979; Gaulden et al. 1964; Santen 1974; Stryker 1979). Perlmutter (1974) noted that many women believe that narcotic addiction causes infertility and are surprised to learn that they are pregnant. Because women heroin addicts frequently do not experience menses, pregnancy often goes undetected until the fifth month of gestation, when fetal life is felt. Dickey and Sowder (in press) concluded that most pregnant addicts have had previous pregnancies. Studies show that over three-quarters of addicted women have had at least two pregnancies. Pregnancy creates a high-risk situation for chemically dependent women and their offspring.

Ostrea and Chavez (1979) point out that the lifestyle of the pregnant addict predisposes her to nutritional deficiencies that may lead to anemia and to a higher incidence of infection. In addition, pregnant addicts are predisposed to a host of maternal complications, including high blood pressure; edema; preeclampsia or toxemia (spilling protein in the urine); blood clots (venous thrombosis); premature separation of the placenta prior to delivery (abruptio placentae); and postpartum hemorrhage (Connaughton et al. 1977).

It has been well documented in the literature that children of addicted pregnant women have higher morbidity and mortality rates than do children of nonaddicted women (Ramer and Lodge 1975). Studies have also shown that babies of addicted women are at high risk to be born prematurely, to have withdrawal symptoms after birth, and to suffer from medical complications (Finnegan 1980; Stryker 1980). The fetus of a drug-dependent woman is at high risk to have several problems during the perinatal period in addition to the neonatal withdrawal syndrome. Before birth, asphyxia is probably the greatest threat to the fetus, followed by aspiration pneumonia (Ostrea and Chavez 1979).

DENTAL PROBLEMS

Andersen's (1977) study showed that 41 percent of the drug-dependent women had dental problems at admission to treatment. Almost 22 percent of the pregnant addicts studied by Stryker (1979) had dental abscesses. Draizin et al. (1975) reported that the DMFT (decayed, missing, or filled teeth) score for drug-dependent women was 23.8 compared with a score of 14.6 for the general population. In addition, Draizin and his colleagues found the following:

- The average methadone patient required five extractions and the restoration of seven teeth.
- Seven out of eight patients required a crown.
- Two out of three required prosthetic appliances.
- Six out of 10 required endodontics.

Dental neglect among drug abusers is due to several factors. First, heroin addicts tend to be from families in lower socioeconomic groups who seldom visit dentists because of the high costs of dental care (Rosenstein 1975). Neglect, inadequate diet, desire for sweets, spastic tooth grinding, and poor dental hygiene all contribute to the high incidence of dental disease found among drug abusers. In one study of methadone clients, 22 percent said they never brushed their teeth while on heroin (Draizin et al. 1975).

AVAILABILITY OF SERVICES

A NIDA-supported study of drug treatment programs geared to treat chemically dependent women (Beschner and Thompson 1981) found that

- 54 percent of the women clients had not received gynecological examinations;
- 74 percent had not received birth control counseling; and
- 83 percent had not received dental care.

Except for methadone programs, which are mandated by Federal regulations to maintain physician coverage, few of the programs surveyed had adequate professional medical resources within their facilities. This dearth of medical services is surprising in view of the extent and complexity of medical and dental problems presented by chemically dependent women.

ACQUIRING HEALTH SERVICES FOR DRUG DEPENDENT WOMEN

If rehabilitation is to be a goal of chemical dependency programs, the health needs of women clients must receive high priority. Given the cost and scarcity of medical resources, it will be a challenge to develop and deliver health services that are sensitive and responsive to the needs of women. New advances in the health field, however, give chemical dependency programs several options in acquiring health services for clients. These developments include

- Self-help and activated patients' programs;
- Use of new health professionals: nurse practitioners (NPs), physician assistants (PAs), and other health workers; and
- The movement from disease-based medicine to health promotion and disease prevention.

This chapter describes how programs can acquire or improve health services for women clients by using self-help and activated patients' models. In addition, methods and techniques for obtaining and using physicians, nurse practitioners, physician assistants, and other health workers will be discussed. The reproductive health needs of chemically dependent women are discussed in chapter 7, this volume. The methods of treating pregnant addicts and methadone-maintained pregnant women and their infants have been described in the following publications and are not covered in this book:

- Finnegan, L. Drug Dependence in Pregnancy: Clinical Management of Mother and Child. Rockville, Md.: National Institute on Drug Abuse, 1980.

- Beschner, G., and Brotman, R. Comprehensive Health Care for Addicted Families and Their Children. Rockville, Md.: National Institute on Drug Abuse, 1977.

SELF-HELP AND ACTIVATED PATIENTS' PROGRAMS

Responsibility for health care has slowly moved away from individual and family practice and toward care by highly specialized professionals. In some communities this trend is now being reversed. People are demanding to know more about their bodies and health care. They are beginning to realize that they cannot afford the high cost of specialized treatment, and that specialists cannot provide accessible and affordable services to many populations. Even if highly technical medical services could be made available to everyone, many doubt whether modern approaches are the most appropriate for promoting well-being.

Our Bodies, Ourselves, produced by the Boston Women's Health Collective (1976), outlines health issues for women in clear, concise terms and provides useful medical information. As more information of this type became available during the 1970s, many women began to demand more control over their bodies, especially in the area of reproductive health. Through consumer education and demand, increasing numbers of women are enjoying access to medical services and information. The following resource materials are readily available to all women (publication data appear in the reference list):

- Contraceptive Technology 1980-1981 (Hatcher et al. 1980);
- How to Stay OUT of the Gynecologist's Office (Federation of Feminist Women's Health Centers 1981);
- My Body, My Health (Stewart et al. 1981);
- The Menopause Book (Rose 1980);
- The Ms. Guide to a Woman's Health (Cooke and Dworkin 1979);
- Women and Health, United States, 1980 (Moore 1980);
- Women and the Crisis in Sex Hormones (Seaman and Seaman 1977); and
- Women's Work, Women's Health (Stellman 1977).

Chemically dependent women, confronted with numerous social, psychological, and physical problems, are generally in the poorest position to take advantage of this new knowledge. A high percentage of these women suffer from low self-esteem, are trapped in dependency roles, and are unprepared to pursue the information and resources needed.

Counselors working with chemically dependent women, therefore, must familiarize themselves with the information contained in these and other books and serve as facilitators and educators for their clients. Chemical dependency programs must actively prepare their clients to assume greater responsibility for their own health needs.

Women can also benefit from recent advances in other aspects of health care. How To Be Your Own Doctor (Sometimes) (Sehnert 1975) is an excellent example of a book designed to give individuals a more vital and active role in their own health care. This book was based on a successful activated patients course at Georgetown University. Chemical dependency programs can use the information in this book to design a health program that teaches counselors and clients how to be their own doctors. As one "activated" patient put it: "Since I've learned to recognize the difference between what looks alarming and isn't, and what doesn't look alarming, but is, my wife and I no longer go running to the doctor or the emergency room for every little thing."

This book can also help programs put together a "black bag." Long the sole domain of physicians, medical instruments have finally made their way into drug stores and American homes. Information gained through use of medical equipment will help program staff and clients make more informed decisions as to whether or not to see a physician. Individuals must make this decision anyway; with medical instruments, they can have more information on which to base their judgment. If a physician is called, the counselor or client will be able to give the physician more information. There is an advantage in being able to tell the doctor the client's temperature, that the tonsils are red and swollen, and that the ears look red, instead of saying that the client needs to see the doctor because she feels sick. While most physicians will appreciate getting such accurate information, some might remind you that you are not a trained physician. At this point it is important for the counselor or client to explain that s/he is just describing what s/he is seeing and is not diagnosing (Sehnert 1979).

Most counselors who work with chemically dependent women can learn how to take vital signs--temperature, heart rate (pulse), blood pressure, and respiratory rate--and learn how to examine the throat and ears. The instruments needed are readily available and include the following:

- Thermometer;
- Ostoscope (for looking in ears);
- Blood pressure cuff (sphygmomanometer);

- Stethoscope (for listening to heart and lungs, and for use with blood pressure cuff); and
- Penlight (for looking in mouth, checking eyes).

A "black bag" containing these instruments can be put together for about $75 (Sehnert 1979). The program may ask local hospitals, physicians, nurses, or pharmacies to donate some of these items. See appendix A for a list of other texts that are useful as general medical resources.

Counselors, other program staff members, and clients should become familiar with women's reproductive health issues and with general health concerns. My Body, My Health (Stewart et al. 1981) is an excellent resource for both program personnel and clients.

ASSISTING CLIENTS

Frequently, program personnel do not address client medical problems when funds or resources are unavailable for medical services. But programs can still help with medical problems by working directly with clients to facilitate the delivery of medical services. For example, counselors can assist in the following areas:

- Identifying problems;
- Motivating clients to make and keep medical appointments;
- Interpreting medical findings in a language the client understands;
- Helping the client comply with medical directions and treatment plans;
- Assuring followthrough on medical referrals; and
- Assuring followup on abnormal physical and laboratory evaluations.

SUMMARY

Whether the program refers clients to physicians or offers medical services onsite, counselors must learn more about health issues to be able to help clients. Programs are urged to take the health needs of their chemically dependent women more seriously, and to recognize that recovery depends on the physical well-being of the client. Even with limited resources, programs can do the following:

- Create staff expertise on health issues;

- Start a health resource library with a few well-selected medical books;

- Put together a black bag of medical instruments; and

- Develop a referral list of physicians, family planning clinics, public health clinics, free clinics, dental clinics, and emergency rooms.

Moving beyond this self-help model, programs will need to identify physicians who are willing to work with drug abuse clients. Many programs find it cost effective to hire nurse practitioners (NPs) or physician assistants (PAs), even if only part time, to provide basic medical coverage for their clients. This approach will be discussed later in this chapter. Because NPs or PAs must often be supervised by physicians, the program will still need to ask the support of a physician. State laws vary concerning duties that PAs and NPs may perform and the degree of physician supervision necessary. The following section explores ways that a program can acquire the services or support of a physician.

RETAINING PHYSICIANS

Drug treatment programs throughout the United States have experienced difficulty in retaining physicians. Although psychiatrists have been willing to work with chemically dependent individuals, general practitioners and other primary care physicians have been more hesitant to become involved. The lack of financial resources and the high cost of medical services have made it difficult, if not impossible, for most programs to hire their own part-time physicians. Methadone programs are an exception because by Federal law physicians must be retained for prescribing and managing chemotherapy. But even methadone programs do not generally provide basic primary medical or gynecological care. Whether the program wishes to establish a part-time general medical practice onsite or whether it must use physicians and medical clinics in the community, the program must first attract concerned local medical providers. By reducing some of the attitudinal and financial barriers, programs should be in a better position to help their clients secure comprehensive medical care.

UNDERSTANDING THE PHYSICIAN'S FEARS IN WORKING WITH DRUG DEPENDENT WOMEN

Many physicians and other health workers believe that the risks of working with chemically dependent individuals far outweigh the benefits. The following is a list of concerns commonly voiced by physicians:

- The physician will be manipulated by clients.

- Clients will constantly try to obtain medications.

- Clients will frequently break appointments without the courtesy of canceling in advance.
- Clients will be "high" on drugs and disrupt the waiting room.
- The physician will be dragged into legal issues involving probation, parole, child abuse, and neglect.
- Clients will not pay for services.
- Other patients will be offended or frightened.
- Chemically dependent individuals are more likely to have multiple and complex medical problems that pose difficult diagnostic and treatment challenges.
- Clients will not complete lab work or X-rays, show up for return appointments, or fill nonpsychoactive prescriptions such as antibiotics.

Whether these fears are based on experience or imagination, it is easy to understand the reasoning behind these concerns. For example, after years of sending prenatal clients to a local obstetrical clinic, a drug program serving pregnant addicts was able to retain the services of a highly respected private obstetrician. The women were seen in his private office and clearly enjoyed the high quality of care. Workers in the program made sure that clients kept appointments, followed through on lab work, and complied with treatment plans. The benefits of being seen by one physician who demonstrated genuine concern for the women cannot be overestimated. This highly beneficial arrangement came to an abrupt halt when the receptionist in the physician's office had her purse stolen by the boyfriend of one of the pregnant addicts. The nurses and receptionist met with the physician and stated that they were afraid to work with this population. With deep regret the physician felt compelled to end his relationship with the program.

To give the reader a first-hand account of what it feels like to be a physician working with chemically dependent women, the author would like to recount a personal experience.

> I have worked with chemically dependent individuals for 15 years and still find that some patients are difficult to manage. For example, a 55-year-old woman whom I did not know called me at home saying she had just had a seizure and hit her head. She also stated that she had migraine headaches and needed Valium immediately. It took me a while to piece together her recent medical history. She said that her family physician was treating her migraines with 40 mg of Valium and four codeine tablets daily. She had been on these drugs for at least 8 months. Allegedly, she abruptly stopped these drugs

> when moving to this area. Her story was convoluted and confusing. Her speech was slow and slightly slurred and she sounded desperate. I explained that she should go to the emergency room immediately. She said she had no way of getting there. I suggested an ambulance. She countered with the fact that she could not pay. I questioned if she could not get to the emergency room how was she going to get to the drug store? She answered that the drug store would deliver. As we discussed the situation I tried to determine the following:
>
> - Was she experiencing Valium or codeine withdrawal?
> - Did she actually have a seizure?
> - Was the seizure a consequence of Valium withdrawal?
> - Did she injure her head during the alleged fall?
> - Was the fall due to the seizure or to alcohol inebriation?
> - Was she speaking slowly because she was loaded or because she had just experienced a seizure?
>
> It is frightening to receive this type of call. I would want to examine this individual in person, but it was evening and she claimed that transportation was not available. I could have said that if she were sick enough, she would get herself to the emergency room. This actually did little to allay my fears. I knew that if she were very confused from the fall, the drugs, withdrawal, or a seizure, she may not be able to clearly evaluate her need for emergency medical care.
>
> My mind raced from a picture of an elderly woman who has had a seizure and has injured her head in a fall, to a picture of a street-wise woman who is adept at hitting up physicians for drugs. I moved between empathy and anger. I decided to give her a prescription for one small dose of Valium to get her through the night and made an appointment for the woman to come to my office the next morning.

Program staff members must understand and appreciate the emotional, ethical, medical, and legal problems that face the physician who chooses to work with chemically dependent individuals. By anticipating these fears and problems, drug programs could design systems that begin to decrease the risks to physicians.

OUTREACH AND EDUCATION TO THE MEDICAL COMMUNITY

It is important to establish chemical dependency as an essential and valid component of modern medicine. Furthermore, it is equally important to establish the credibility of the particular drug program. Both goals can be accomplished through vigorous outreach and education activities aimed at the local medical community. Possible initial contact points may include the following:

- Public health nurses;
- Continuing education or in-service training coordinators at the local hospital;
- Community health clinics;
- Community mental health centers;
- Local public health departments;
- Medical societies;
- Physicians who have supported the program or have been willing to see some of the clients or children of clients;
- Premed and medical students;
- Physicians active in drug treatment from other communities;
- Clinical social workers in the local hospital; and
- Emergency room staff.

Some physicians are involved in continuing education efforts sponsored by local hospitals. Often, monthly or more frequent training meetings are scheduled by specialty area to discuss the latest medical information. These meetings are usually called "grand rounds." The specialty areas that might be interested in presentations regarding chemical dependency include family practice, pediatrics, obstetrics/gynecology, psychiatry, and internal medicine.

A program should decide which specialty area to approach first based on the program's need and the availability of a contact person in that area. For instance, programs needing assistance with pregnant addicts should first approach the pediatric or obstetrical specialists. An advocate (a nurse, physician, or social worker) in the specialty could help arrange a meeting.

The obstetricians in a private hospital in San Francisco played a crucial role in obtaining services for pregnant addicts in a methadone program. To find a physician who will work with chemically dependent women, program staff should talk with pediatricians, social workers, and physicians already working with public health clinics or community clinics.

When arranging presentations for medical staff, try to be informative and responsive to the concerns of the participants. Some health workers may feel that they know enough about chemical dependency and have already decided not to work with this population. The presentation should include information about new developments in the field, effects of new drugs, and demographics of different drug-using populations. Some topics that might spark interest include the following:

- The epidemiology and etiology (both biochemical and psychosocial) of chemical dependency.
- Drug use patterns and trends, including new drugs and drug combinations being used, e.g., phencyclidin (PCP), Talwin and Pyribenzamine (Ts and blues), and Doriden and codeine (Dors and Fours).
- Occupational hazards involving chemical dependency in the health field.
- New methods of identifying, managing, and detoxifying individuals who are dependent on prescription drugs.
- Results from hospital emergency room drug overdosage studies: treatment implications and referral sources.

If a physician in the community is well versed in chemical dependency, s/he may be willing to give a presentation to other medical workers without charge. If the drug program wants to bring in a resource person from outside the community, however, it is customary to offer payment for travel, food, and lodging and an honorarium.

After good rapport is established with someone from a local hospital, the program can look for ways to pay for the guest speaker. Programs might have funds set aside to pay for in-service training, grand rounds, or other continuing education projects. Other potential sources of funding include the following:

- Local public health department;
- State drug abuse agency;
- Local or State chapter of the American Medical Association;
- Pharmaceutical companies;
- Pharmacy associations; and
- Nurses' associations.

Pharmaceutical companies support physician education programs, especially when the costs are minimal. A local pharmacist can help identify area pharmaceutical companies.

Physicians with knowledge of chemical dependency can be located through the county public health office, the Single State Agency (SSA) for Drug Abuse, the National Institute on Drug Abuse, substance abuse committees of the State or county chapters of the American Medical Association, and the California Society for the Treatment of Alcoholism and Other Drug Dependencies. The last organization is a specialty society for physicians experienced in research or treatment of alcoholism and other drug dependencies. Membership is open to qualified physicians from all States. For help in locating speakers and physicians, contact the society at 731 Market Street, San Francisco, Calif. 94103. The society publishes an informative quarterly newsletter available to members and nonmembers.

It might be possible to convince the SSA of the value of discussing certain medical topics statewide. The SSA might be able to hire a physician or group of physicians as consultants to give presentations throughout the State. For instance, in the mid-1970s, the California Substance Abuse Agency felt the need to educate both medical and drug treatment communities on care and treatment of the pregnant addict and the passively addicted newborn. The State hired a part-time consultant to give presentations throughout California. A State employee was assigned part time to arrange the presentations and to assist local communities with publicity, facility selection, and other details. She also helped the consultant with travel and audiovisual arrangements. Local hospitals were carefully selected to attract the largest number of physicians and nurses. The presentations emphasized the unique medical issues and needs of each specialty area. The outcome exceeded all anticipations. Communities reported a ripple effect that included the following results:

- Medical personnel and drug treatment providers were encouraged to work together.
- The value of the work of drug treatment programs was upgraded in the eyes of the medical personnel.
- Open communication, both formal and informal, was created for enhancing continuity and coordination of care for pregnant clients.
- Links were established among medical units that had been at odds with each other, for example, pediatrics and obstetrics/gynecology at one hospital, and psychiatry and obstetrics at another hospital.
- The awareness and interest of medical staff were increased so that they became more involved with local drug programs.

The State's investment for the year was minimal considering the number of communities and individuals reached.

To carry out successful presentations, the speaker must be well versed in his or her field, well prepared with slides or films, and have a dynamic style of presentation. The goal is not only to educate, but also to create some cognitive dissonance and to change attitudes. An interesting, informative presentation given by a knowledgeable physician can do much to increase the credibility of drug treatment programs and attract more health workers to the field.

NETWORKING

In setting up a presentation, drug programs and the medical community will begin to work together. Because this task is not particularly threatening, it provides a good starting point for communication. Building on these initial contacts is an essential step in developing medical resources.

The program could develop a questionnaire that asks health care workers whether they would like to be involved in specific areas. But programs should be careful not to overwhelm these professionals; they work at full-time jobs and probably have other outside commitments. Find out which committees are already meeting at the hospital and explore with interested health workers which ones might be appropriate for discussing medical issues and chemical dependency. Where possible, have followup meetings at the hospital with a few people who have stated their interest. The specific topics to be explored will depend on the unique needs of the drug program.

DELINEATING THE SERVICES AND PROVIDERS

Treatment programs vary greatly in the types and quantity of medical services they provide. The types of providers will also vary; there is no basic formula. Individual program design should be based on resources available in the community, client needs, and programmatic and fiscal restraints. All treatment programs should try to provide the following services to women clients either onsite or through referral:

- Comprehensive medical histories;
- Physical exams, including pelvic exams, Pap smears, wet mount slides for vaginitis, and basic office gynecological services;
- Family planning information and services;

- Tests for pregnancy, gonorrhea, syphilis, tuberculosis, liver dysfunction, thyroid disease, and others when appropriate;

- Services for acute illnesses such as colds, abscesses, and lacerations;

- Referral to specialty services, when appropriate; and

- A 24-hour answering service.

Individuals who are permitted to provide this basic medical coverage are

- Nurse practitioners, under the supervision of a physician;

- Physician assistants, under the supervision of a physician; and

- Physicians, including general practitioners, family physicians, internists, and gynecologists.

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

A pamphlet entitled "Nurse Practitioners and Physician Assistants in Substance Abuse Programs" (National Institute on Drug Abuse 1979) is available through the Alcohol, Drug Abuse, and Mental Health Administration, 5600 Fishers Lane, Rockville, Md. 20857. This publication outlines the use of new health professionals in chemical dependency programs. For example, it points out that NPs and PAs have been found to be most cost effective when allowed to carry their own caseloads, consult with physicians as necessary, and refer patients to other health professionals when a patient's needs are beyond their treatment capacity.

Often, the services of the NPs and PAs are reimbursed by third-party medical payors, but a backup physician usually must make the claim. Program administrators should contact local third-party payors to determine the criteria used, qualification requirements, and the paperwork involved.

Studies have shown that the quality of NP and PA services can be as high as that of physicians performing the same service (National Institute on Drug Abuse 1979). Negligence litigation against NPs and PAs is rare, and programs can protect themselves by properly identifying NPs and PAs to clients, asking NPs and PAs to follow written protocols for patient treatment, and securing appropriate malpractice insurance (National Institute on Drug Abuse 1979). One way to evaluate potential NPs and PAs and learn how to use them is to let them participate in the drug abuse program as part of their clinical field work. All PA and NP training programs require clinical experiences. Providing a site for clinical training is one way to recruit employees while exposing the program to these health professionals on a trial basis.

PA clinical training is often based on the medical model of rotating 6-week internships. NP programs usually require a single preceptorship of from 6 to 12 months. Many programs require the students to be sponsored by an organization that will also arrange for the preceptorship. Substance abuse programs could sponsor a currently employed registered nurse in a nurse practitioner training program or offer short-term clinical experiences in substance abuse to NP students (National Institute on Drug Abuse 1979).

Further information regarding NPs and PAs is available from the associations and boards listed in appendix B or by reading the selected material outlined in appendix C.

IN-HOUSE CLINICS

Some chemical dependency programs have been able to open their own medical offices that not only support themselves but also generate money for the clinic. Using NPs and PAs, with a backup physician, these programs are able to provide medical services to clients, generate funds, and keep costs down. Even if physicians were hired part time to deliver services, an in-house medical program could still realize an income sufficient to pay for the physician's hourly wage and other expenses. Establishing a one-room examination office for general medical care and office gynecology costs approximately $6,000. This figure includes the cost of equipment and supplies, not rent. Local pathology labs can help programs set up an examination room with centrifuge, specimen drawing equipment, vials, culture media, and mailers at no cost. (They will be making a profit on the lab work sent.) If all lab tests can be done onsite, clients will not have to be sent to a separate lab.

Typically, in-house clinics have served the medical needs of chemically dependent clients. One program in Santa Cruz, Calif., runs a comprehensive health clinic for all women 2 days a week. The clinic generates funds for the chemical dependency program and is also a major source of referral into the chemical dependency program. This clinic is expanding to a 5-day-a-week service with the assistance of a nurse practitioner. Expanding medical services to include nonclients may be cost effective and should be explored. Because medical services are reimbursable by third-party payors, and because PAs and NPs are becoming increasingly available, establishing an in-house clinic may be an attractive, cost-effective addition to a substance abuse program.

HEALTH SERVICE FUNCTIONS

Whether medical services are provided in-house or through referral, several health-related functions must be carried out by program staff. The health service functions described here can be performed by a variety of individuals, from trained volunteers to health professionals. Regardless of who performs the functions, they must all comply with the Federal confidentiality regulations (Federal Register 1975), Title 42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

The tasks described here are

- Health services coordination,
- Health advocacy, and
- Primary counseling.

HEALTH SERVICES COORDINATION

Depending on the size of the program, this task typically can be performed part time. In one methadone program, a secretary carried out this task.

While a program is in the initial steps of establishing referral medical services, the following types of arrangements should be made with the provider physician or clinic.

- Program will estimate number of clients who will be referred per week or month.
- Program will ask which days are best for referring clients to physician's office.
- Program will assure that client will have medicare or medicaid cards prior to appointment.
- Program will assure that all medical history forms and financial forms are filled out accurately by the client before arriving at the physician's office.
- Program will assure that client will comply with treatment, including obtaining X-rays and lab work.
- Physician's office will supply the drug program with copies of any forms that should be filled out by client.
- Physician will fill out medical forms and return these to the program.

Referral arrangements should comply with title 42 of the confidentiality regulations (Federal Register 1975), obtaining the client's consent or a qualified service organization agreement. Although the executive director may want to be involved in this initial process, a staff member should be responsible for the ongoing coordination of these services. To design a system that the staff can understand and support, staff input should be solicited.

The health coordination tasks typically include the following:

- Identifying a new client.
- Scheduling an appointment for a physical exam.
- Securing release of information for past medical records in compliance with the confidentiality regulations.
- Assisting the client with medicare and medicaid.
- Assuring that the client completes the medical history forms, financial forms, and any other paperwork required by the medical practice.
- Assuring attendance at medical appointments.
- Following through on medical treatment, assuring compliance.
- Following up on medical exams, laboratory evaluations, referrals to specialty clinics, or special lab procedures.

Clients should have a complete physical exam within the first 21 days of treatment. Before entering a residential program or being placed on methadone or a detox regimen, clients also should have a complete physical exam. Clients entering a residential program should be screened for communicable diseases in order to protect other clients and staff.

A screening system should be designed at intake to identify all new clients and to arrange medical appointments. A client might say she has just received a medical exam elsewhere; in that case, get a release from the client to obtain this medical information. Ask the local hospital what kind of release form they require to release information obtained in a medical examination. The reporting of test results must be done by consent form, a qualified service organization agreement, or an authorizing court order (Federal Register 1975). Regardless of the type of consent form required by the local hospital, the program cannot release information unless the consent complies with section 2.31 of the confidentiality regulations. Obtaining this information is important because the exam that was performed may not have included all the elements covered in the program's physical, and also because it may not be necessary to repeat costly tests and procedures that were recently completed. A tickler system should be designed that shows which records have not been received. Often program staff must call physicians and hospitals to remind them to send the client's medical records.

Because obtaining these records may take time, a program may want to establish the policy that all clients receive a thorough physical exam, including pelvic exam, if the program does not receive the medical records within 2 weeks of intake. There is no need to repeat a Pap exam so long as records show that a test given within the past 6 months was negative.

Having the client prepare history and financial forms at intake instead of in the physician's office should speed the process and relieve some of the burden on the medical staff.

The staff person in charge of health coordination should also become familiar with the local medicare and medicaid systems. Meeting with the eligibility workers is an important link. Once the coordinator understands the application procedures, s/he should write up instructions that can be given to all clients. The eligibility worker can be asked to review a draft of the instructions to assure accuracy. Appendix D is an example of a form used by a clinic in California.

The program should establish ongoing liaison with an eligibility worker at the local medicare/medicaid office. In this way, if any difficulties arise at least one person will be available who is familiar with the program's population. These connections should be established prior to an emergency. People in other agencies will be more responsive if they are involved in planning a well-thought-out system instead of being asked to react immediately to a crisis. Referrals for medicaid and medicare eligibility and billing must be done with the client's consent.

If a client is ineligible for assistance programs, program staff should explore with her other ways of financing medical care. It is easier to explore various options when this subject is approached in a direct and straightforward manner. By assuming responsibility for their own medical services, clients will learn to be more independent.

The possibility of health insurance should be explored for persons who are ineligible for medicaid. Health insurance companies are eager to provide material showing clients the types of benefits available and the costs involved. Learning to plan ahead for medical services and budgeting will be major skills that the health coordinator can help teach to the clients.

Even if a client is not eligible for total coverage under medicaid, she may be eligible for medicaid with a "spend down." A spend down is like a deductible. Depending on income, the client may have to spend, for example, $50 on medical services before medicaid will begin to pay. In some instances, the physician may be willing to forego this $50 financial fee and incur a financial loss. Spend downs can be discussed with both the physician and the client. In some situations, the spend down may be so great that the client would be better off paying for private insurance.

After the general agreements are established, the health coordinator should train and supervise the counseling staff in the area of health issues. He or she must assure that all clients receive comprehensive medical exams, that all forms have been filled out accurately and filed in the client's record, and that there is followthrough on all positive findings. The health services coordinator should take an active role in designing and implementing the client's medical and health treatment plan.

HEALTH ADVOCACY

If a program has a physician or nurse who is sensitive to the needs of chemically dependent women, it may not need the services of a health advocate. When a client is sent out for physicals, specialty lab testing, or medical appointments, however, having a health advocate accompany the client is extremely beneficial. The health advocate makes sure that the client obtains satisfactory and timely services, has a clear understanding of the results, and follows through as directed (obtains prescriptions, etc.). The health advocate can also help the client obtain transportation, a major obstacle for many women.

In addition, a health advocate can act as a go-between for the client and medical professionals. For example, some clients may still be using drugs or experiencing the discomforts of withdrawal during the first physical exam. These conditions can affect their ability to give accurate information as well as their ability to understand the information given to them by physicians. (Health advocates should always be aware of title 42, part 2, of the confidentiality regulations [Federal Register 1975].) In one instance, a lab technician told a pregnant addict that she could not see the baby's head on the sonogram (a picture of the unborn baby made by passing sound waves over the abdomen of the mother). The woman became distraught and later took a large dose of heroin because she thought the technician said her baby did not have a head. The picture just needed to be retaken. This kind of situation can be alleviated by having a health worker accompany the client.

The health advocate also teaches the client how to negotiate the complex medical services system. More advanced clients in treatment can also act as health advocates for newer clients after they have received some training through the program or organizations in the following list. Acting as advocates lets these clients share and practice their newly acquired skills within a safe environment. The program's health coordinator should be available to back up the health advocate should difficulties arise. Natural places to look for potential volunteer health advocates include the following:

- Women's clinics;
- Premed students at local colleges and universities;
- Health consumer advocates known to or active in the regional health systems agency, department of public health, or local mental health and drug advisory boards;

- Volunteers trained by Planned Parenthood;
- Gray Panther organizations and programs that place elderly citizens in jobs; and
- CETA and VISTA programs.

Schools that have ongoing training for health advocates may be willing to train treatment program volunteers. In return, the program can offer an exchange whereby it trains their staff on issues relating to chemical dependency. This training is important; the health advocate will be the program's representative at the physician's office. This person must be able to communicate clearly, be reliable, and have the capacity and knowledge to understand the needs of both the client and the physician.

PRIMARY COUNSELING

The primary counselor is the contact person for the client and as such is the natural person to monitor the health treatment plan. This person should make sure all medical forms and related correspondence are in the client's file. The counselor generally helps set up the medical appointment, gives the client written information regarding medicaid, and helps the client fill out medical history and financial forms. The counselor must find out if the client has any medical problems that need immediate attention. If so, the counselor should work with the health coordinator in securing an early medical appointment. Once the health treatment plan is established, the primary counselor is responsible for assuring that elements in the health treatment plan are carried out and that the plan is evaluated periodically and revised as appropriate. For example, if a client were being treated for trichomonas vaginitis (a vaginal infection), the primary counselor would make sure that the client and her partner have taken their medication. The counselor would then make an appointment for a followup visit to the physician to assure that this communicable infection was adequately treated. If the client is unreliable, she can be asked to bring her medication to the clinic and take it in front of the counselor. The health role of the primary counselor is demonstrated in the following example.

One client was told that she had trichomonas vaginitis. This infection is passed on through sexual contact, and the client was told that she and her sexual partner(s) should be treated with Flagyl. She lived with two men, one of whom was her boy friend. Although she did have sexual relations with the other roommate, her boy friend did not know about it. She was afraid to tell them that they both had to take Flagyl. She stated that her boy friend was very jealous and was also an alcoholic. The combination of Flagyl and alcohol can cause nausea, vomiting, abdominal cramps, and headaches. Furthermore, although the client was covered by medicaid, her boyfriend and roommate were not. The client stated that she did not have the cash to pay for their prescriptions.

Compliance would entail discussion with the client about how she could approach the problems of secrecy, alcoholism, and finances. Typically, a physician would not have the time or perhaps even the skill to work through these issues. In situations like this, the primary counselor is indispensable. Problems can be quite delicate requiring the sensitivity of a skilled counselor. Besides handling the client's emotional concerns, the counselor will also need to provide the client with technical information regarding vaginitis, using appropriate health information resources.

MEDICAL FORMS

Putting time and effort into a client's initial comprehensive medical evaluation provides an assessment and diagnosis of the client's medical status and introduces the client to a health system that she can use even when she terminates treatment. The program staff should design simple, efficient forms that transmit information from the physician to the counseling staff. The program may use a family practice clinic at the local public health department or hospital, a family practice physician, or several family practice physicians. In each case, the functions of health coordination, health advocacy, and primary counseling need to be closely coordinated. For programs that hire a part-time physician, nurse practitioner, or physician assistant and see patients onsite, the basic logistical problems are the same. Getting complete and accurate records from the physician to the counselor is a challenge whether the physician is in the next room or the next city. The medical forms suggested here can be used in either setting.

When approaching a potential medical care provider, program staff must demonstrate that they have thought about the potential logistical problems and have developed rough drafts of various forms that may be helpful. It is important to show that the program has useful ideas about how it can assist the physician or clinic and yet remain responsive to their particular needs.

Physicians usually have their own medical history and physical exam forms. A typical history form is included as appendix E. Medical histories have been advanced by the work of Robbins and Hall (1970) and Hall and Zwemer (1979), who developed the Health Hazard Appraisal. Systems like the Health Hazard Appraisal should be an integral part of every comprehensive medical history and exam. Unfortunately, few physicians are actively involved with this kind of system. The Health Hazard Appraisal does not need to be administered or evaluated by a physician, however. The person doing health coordination can become adept at administering, evaluating, and interpreting the standardized form. The Bodywork Book (Haessler and Harris 1980) describes how to evaluate the Health Hazard Appraisal. Although the traditional medical history form stresses past medical illnesses of the client and the client's family, the Health Hazard Appraisal form stresses lifestyle habits.

If a program is fortunate enough to find a physician who is eager to work in the area of health promotion and disease prevention, all the better. If not the chapter entitled "Health Promotion for Chemically Dependent Women" in volume II of this book should be helpful. It provides information, resources, and references on this subject.

The main purpose of designing reporting forms is to document and transmit accurate information regarding the client's health status from the physician to the program staff. One of the basic record-keeping styles is the "SOAP" method. Each letter of this acronym stands for a different part of the medical evaluation:

- Subjective: The problems the client believes she has; her chief complaint. This is usually written in the client's own words--for example, "I have a sore throat and a fever."

- Objective: These are the findings the physician, physician assistant, or nurse practitioner observe during the visit, including

  1. Family and individual medical history;

  2. Vital signs, height, weight, blood pressure, temperature;

  3. Results of physical exam; and

  4. Lab and X-ray results.

  The objective findings for a woman with a complaint of sore throat may include an elevated temperature, red swollen tonsils with white spots, and swollen and tender lymph nodes on the neck.

- Assessment: This is the diagnosis or statement of the problem or problems. Sometimes more information is needed to make a definitive diagnosis. The problem should be stated at the greatest level of accuracy possible with all the information currently available. If one problem may be due to a number of causes, the physician will then write "RO" or "Rule Out," and then list the causes that need to be evaluated further. "Rule Out" means "consider as a possibility." For instance, in the sore throat case, the assessment would read:

  1. Tonsilitis--probable strep
     RO Infectious mononucleosis
     RO Viral tonsilitis

- Plan: This includes the treatment plan and delineates further steps that need to be taken. In some situations, the assessment will be so evident that a clear treatment regimen might follow. In other cases, the assessment may call for further evaluation demanding X-rays, lab work, or referral to specialists. In other situations, the physician may start some definitive course of treatment and still attempt to get more information. Continuing with the sore throat case, the physician will be treating what is considered a strep tonsilitis but will still evaluate the other possibilities.

1. Ampicillin 250 mg tab, one tab every 6 hours for 10 days.

2. Monospot test to rule out mononucleosis.

3. Complete blood count with differential.

4. Throat culture to confirm streptococcal infection.

In this way, the physician begins treating what s/he thinks is most likely a strep throat but still explores the possibility that it might be mononucleosis.

If multiple problems are found, they are listed separately in the assessment, and plans should be listed separately for each problem.

When health workers keep these types of records, it is easy for a lay worker to understand what is going on. Program staff may need to ask the physician or nurse practitioner to take the time to write the terms in longhand.

A physician's commonly used abbreviations can be found in a medical dictionary. The staff should also find out any specific abbreviations the physician uses. For example, a legend typed up by the physician's office may look like this:

c̄ = with
o = without
ṫ = one
ṫṫ = two
ṫṫṫ = three
qd = daily
bid = twice a day
tid = three times a day
qid = four times a day
HS = hour of sleep (at bedtime)
PO = orally
IV = intravenously
q 6 hrs = every 6 hours
X = times

Other Latin terms and abbreviations are included in appendix F.

When a physician understands that these forms will be read by laypersons who are genuinely interested in assisting with the medical care of the patients, s/he may be eager to be more informative. With a legend of commonly used abbreviations and cooperation from the physician, interested counselors should be able to read and understand the medical forms. One rule that should be stressed: If you don't understand, ask. Don't guess what's in the record or what someone meant. The medical resource library suggested earlier in this chapter will also help program staff understand the client's medical conditions and prescribed treatments. The physician, nurse practitioner, and physician assistant can help staff of drug and alcohol programs in selecting the most useful resource books.

MEDICAL FORMS

Three forms are included here to demonstrate the kind of information that should be transmitted from the physician to the drug program. Explanation of each form and its abbreviations follows.

- Medical Form #1: Comprehensive Physical Exam and Medical History.
- Medical Form #2: Laboratory Tests and Results.
- Medical Form #3: Acute Medical Services.

Medical Form #1: Comprehensive Physical Exam and Medical History. Medical Form #1 is a detailed outline of the positive findings.

Although the physician should have a detailed history form such as that in appendix E, it is not necessary for the program to know the specifics outlined in the history. The physician should transcribe important positive findings to this medical form. The family planning history is important in a population of chemically dependent women. Therefore, this medical form asks detailed questions to highlight the issue for the physician and to alert the drug program counselor of any difficulties in this area. Much of the responsibility for discussing family planning may rest with the primary counselor. The counselor should inform the client about birth control services and address client concerns about pregnancy and birth control (see chapter 7, this volume).

The systems listed here will guide the physician in understanding the type of physical exam expected. Most of the notations are self-explanatory, but some of the terms will be explained here.

- Gen. Dev.: General development.
- Dev. Sep.: Deviated septum in the nose.
- Tonsils abs.: Tonsils absent.
- Tonsils path.: Tonsils pathological (diseased).

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MEDICAL FORM #1

COMPREHENSIVE PHYSICAL EXAM AND MEDICAL HISTORY

DATE: ______________ CLIENT: ______________________

DOCTOR: ______________________

Please report all positive findings.

I. SUBJECTIVE

II. OBJECTIVE FINDINGS

A. HISTORY

1. Medical history of family of origin:

2. Client's medical history: Please indicate whether illness is active or resolved.

3. Family Planning History:
Menstrual history ______________________
Presently using birth control method? ___ Type _____
Has used birth control pills? ___ Type _____
Duration ____________
Has used IUD? ___ Type _____ Duration ________
Problems encountered with IUD or pills ________
Diaphragm _____ When was this last fitted? ________
Condoms ______ Uses foam with condom? ________
Tubal ligation _________

MEDICAL FORM #1 (continued)

DATE: ______________ CLIENT: ________________________

II. OBJECTIVE FINDINGS

B. PHYSICAL EXAM
Legend: WNL = Within Normal Limits, 0 = Absent, N.E. = Not Examined. Abnormalities should be described.

Height ________ Weight _______ Temp. _______

Gen. Dev.: Thin ____ Med ____ Thick ____ Obese ____

Head ____

Eyes ____

Vision: R _____ L _____ Corrected: R _____ L _____

Ears ____

Hearing: Right __________ Left __________

Nose & Throat: Norm ____ Spur ____ Dev. Sep. ____

Tonsils: Norm ____ Abs. ____ Path. ____

Teeth and Gums ____________________________________

Neck ________________________ Thyroid ____________________

Chest ____

Breasts ____

Heart ____

Pulse ________________________ B.P. ____________________

Lungs ____

Abdomen ______________________ Palpable Organs ____________

Hernia ____

Pelvic

External ________________________

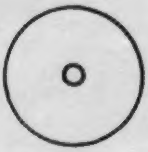
Vagina:
  Cystocele __________
  Rectocele __________
  Other __________

Cervix ________________________

Uterus ________________________

Adnexa ________________________

Rectovaginal ____________________



MEDICAL FORM #1 (continued)

DATE: ________________ CLIENT: _________________________

Back ____

Extremities ______________ Joints __________________________

Patellar reflexes: R ___________ L _____________

Skin ________ Acne ______ Tracks ______ Abscesses ______

Lymph nodes: Cerv. _______ Ax. _______ Ing. _______

Other abnormal findings ____________________________________

____

Urinalysis ____

Wet mount for vaginitis ____________________________________

ASSESSMENT: ____

____

____

____

____

PLAN: ____

____

____

____

NOTES TO PROGRAM: Ways in which program staff can assist in the medical plan.

____

____

____

FOLLOWUP APPOINTMENT: YES ____ NO ____

Date: ______________ Time: ______________

Place: _________________________________

Service: _______________________________

____

PHYSICIAN'S SIGNATURE

- B.P.: Blood pressure.
- Palpable organs: Liver, kidneys, spleen.
- Cystocele: Where the bladder wall prolapses (falls) through the vagina.
- Rectocele: Where the rectum prolapses through the vagina.
- Adnexa: Ovaries and fallopian tubes and their ligaments.
- Lymph nodes

  Ax.: axillary (arm pits).

  Ing.: inguinal (groin).

The diagrams are sketches of the breasts and cervix (the tip of the uterus that dips into the vagina). If any abnormalities are found with the breasts or cervix, the physician can draw the location, size, and appearance on this diagram.

One section on the form is called "wet mount." Because many of the women will have abnormal vaginal discharges, the physician should examine the discharge under a microscope to make an accurate diagnosis. The discharge is placed on two microscope slides, one with a drop of saline (salt water) solution and one with a solution of potassium hydroxide. These slides are called wet mounts. Trichomonas and bacterial vaginitis will show up on the saline slide, whereas monilia yeast infection will be seen on the potassium hydroxide slide. If the diagnosis of vaginitis is made, the physician must state the exact nature of the vaginitis, if known, since treatment will differ in each case. The assessment will then list the problems by number, and the plan should outline the activities to be carried out for each problem.

The "Notes to Program" section is an essential part of this form. This space gives the physician the opportunity to tell the drug program counselor exactly what s/he can do to assist in the medical treatment of the client. This assistance can take many forms, such as making sure that the client takes her antibiotics, helping the client make followup appointments, or spending time counseling the client about a specific problem.

Medical Form #2: Laboratory Tests and Results. Since medical form #1 should be filled out during the comprehensive exam and returned to the program via the health advocate at the end of the visit, a second form will be needed to transmit the lab results that will not be ready for a few days. Medical form #2 can be used to communicate the lab results to the program. Again, a shorter form is permissible so long as it specifies which tests were performed. The tests listed here are those commonly used in a population of chemically dependent women. Certainly, it would be rare to require all the tests for any one client. The decision regarding which laboratory tests to order is a matter of clinical judgment and is based on the findings from the physical exam and the medical history.

The physician is asked to note the exact hematocrit and hemoglobin values. Since women are at risk for blood loss and anemia, it is important for each woman to know her own normal value. There is a wide range of normals, and a woman's blood value may drop but still register in the normal range. The counselor can write down the client's hematocrit for her, along with her blood pressure and any abnormal findings that must be followed.

Medical Form #3: Acute Medical Services. Medical form #3 is used when the client sees a physician for a specific complaint, such as a sore throat or difficulty with menstrual periods. After the comprehensive form is filled out, this is the medical form that will be used most frequently to communicate information from the physician or specialist to the program. This form would be used for the woman with a sore throat given as an example earlier in this chapter.

Using these forms as guidelines, the drug program and the physician can develop forms that reflect their needs as well as the unique needs of their client population.

MEDICAL FORM #2

LABORATORY TESTS AND RESULTS

DATE: ______________ CLIENT: ________________________

DOCTOR: ________________________

Legend: WNL = Within normal limits, NT = Not tested, P = Results still pending

Please state actual hematocrit and hemoglobin values even if these are within normal limits.

---

1. Complete blood count and differential ______________________
2. Pap smear ______________________
3. Wet mounts for vaginitis ______________________
4. Gonorrhea culture ______________________
5. Serologic tests for syphilis ______________________
6. Routine and microscopic urinalysis ______________________
7. Urine screening for drugs ______________________
8. Chemical screen profile (SMA 12/60) ______________________
    Liver function ______________________
    Kidney function ______________________
    Thyroid ______________________
    Electrolytes ______________________
    Other ______________________
9. Tuberculosis test ______________________
10. Chest X-ray ______________________
11. Mammography ______________________
12. Pregnancy test ______________________
13. Sickle cell test ______________________
14. Australian antigen ______________________
15. Electrocardiogram ______________________
16. Other tests ______________________

ASSESSMENT:

PLAN:

____
PHYSICIAN'S SIGNATURE

MEDICAL FORM #3

ACUTE MEDICAL SERVICES

DATE: ____________

CLIENT: ____________

DOCTOR: ____________

Telephone No.: ____________

Address: ____________

SUBJECTIVE FINDINGS:

OBJECTIVE FINDINGS:

ASSESSMENT:

PLAN:

NOTES TO PROGRAM: Ways in which the program staff can assist in the medical plan.

PHYSICIAN'S SIGNATURE: ____________

APPENDIX A
REFERENCE SOURCES

MEDICAL DICTIONARIES

- Dorland's Illustrated Medical Dictionary
- Gould Medical Dictionary
- Stedeman's Medical Dictionary

GENERAL MEDICINE TEXTS

- Textbook of Medicine, Beeson-McDermott
- Principles of Internal Medicine, Harrison

GENERAL DRUG INFORMATION

- United States Pharmacopeia (USP). Provides mongraphs of official drugs describing dosages, uses, and information dispenser of drug must tell patients; gives standards for drug manufacture.
- Physician's Desk Reference (PDR). Information is provided by manufacturers, who pay to have drug listed. Lists therapeutic uses, doses, side effects, and contraindications. Contains tablet identification (pictures) section. Is cross-indexed by brand name, generic name, therapeutic use, and manufacturer name.

NONPRESCRIPTION DRUG INFORMATION

- Handbook of Nonprescription Drugs. Published by the American Pharmaceutical Association, discusses nonprescription drugs by therapeutic class. Is the only resource available that lists the constituents of nonprescription products.
- The Medicine Show. Published by Consumer's Union, it contains a glossary of medical terms and chapters on information concerning other areas of consumers' medical interest (e.g., "Drugs in Pregnancy," "How to Stock a Medicine Cabinet," "How to Look for a Family Doctor").

PRESCRIPTION DRUG INFORMATION

- The Pharmacologic Basis of Therapeutics, Goodman, L.S., and Gilman, A., eds. 6th ed, Macmillan, New York, 1980.
- The Essential Guide to Prescription Drugs, Long, J. Harper and Row Publishing Co., New York, 1980.

EVALUATION OF SYMPTOMS OR MEDICAL PROBLEMS

- The Common Symptom Guide, Wasson, J. McGraw-Hill Publishing Co., New York, 1975. Is diagnosis-oriented, has a clear index with good cross-indexing.
- Take Care of Yourself--A Consumer's Guide to Medical Care, Vickery, D., and Fries, J. Addison-Wesley, Reading, Mass., 1976. Is very clear and concise. Contains a section to keep family records. Contains chapters on areas of consumer medical interest (e.g., "The Home Pharmacy," "Reducing Your Medication Costs").

JOURNALS

Journal of the American Medical Association
535 N. Dearborn Street
Chicago, Ill. 60610

New England Journal of Medicine
10 Shattuck Street
Boston, Mass. 02115

British Journal of Addiction
Longman Group, Ltd., Periodicals & Directories Division
Longman House, Burnt Mill, Harlow, Essex CM 20 2JE
England

Clinical Pharmacology and Therapeutics
11830 Westline Drive
St. Louis, Mo. 63141

Journal of Psychedelic Drugs
STASH Press
638 Pleasant Street
Beloit, Wisc. 53511

Medical Letter of Drugs and Therapeutics
56 Harrison Street
New Rochelle, N.Y. 10801

Science
1515 Massachusetts Avenue, N.W.
Washington, D.C. 20005

Quarterly Journal of Studies on Alcohol
Rutgers University
New Brunswick, N.J. 08903

Law and Society Review
Law and Society Association
University of Denver, College of Law
200 W. 14th Avenue
Denver, Colo. 80204

International Journal of the Addictions
Marcel Dekker Journals
P.O. Box 11305
Church Street Station
New York, N.Y. 10249

APPENDIX B
SOURCES OF INFORMATION ON PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

PHYSICIAN ASSISTANT INFORMATION

American Academy of Physician Assistants
2341 Jefferson Davis Highway, Suite 700
Arlington, Va. 22202
(703) 920-5730

National Commission on the Certification of Physician Assistants
3384 Peachtree Road, N.E., Suite 560
Atlanta, Ga.
(404) 261-1261

State Board of Medicine, usually located in the State capital

State Physician Assistants' Association (names and addresses available from the American Academy of Physician Assistants)

Primary Care Education Branch
Division of Medicine
Bureau of Health Manpower
Health Resources Administration
U.S. Department of Health and Human Services
3700 East-West Highway
Hyattsville, Md. 20782
(301) 436-7350

NURSE PRACTITIONER INFORMATION

American Nurses Association
2420 Pershing Road
Kansas City, Mo. 64108
(816) 474-5720

National League for Nursing
10 Columbus Circle
New York, N.Y. 10019
(212) 582-1022

State Board of Nursing, usually located in State capital

State Nurses Association, usually located in State capital

NP Training Section
Division of Nursing
Bureau of Health Manpower
Health Resources Administration
U.S. Department of Health and Human Services
3700 East-West Highway, Room 3-41
Hyattsville, Md. 20782
(301) 436-6670

APPENDIX C
BOOKS, ARTICLES, AND PUBLICATIONS ON PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

SELECTED BOOKS AND ARTICLES

McDougle, M., et al., Nurse Practitioners and Physician Assistants in Drug Abuse Treatment. Research Triangle Park, N.C.: Research Triangle Institute, July 1977. (NIDA Contract No. 271-75-1016)

National Health Practitioner Program Profile--available for $7.50 from Association of Physician Assistant Programs, 2341 Jefferson Davis Highway, Suite 700, Arlington, Va. 22202.

Bliss, A.A., and Cohen, E.D., eds. The New Health Professionals: Nurse Practitioners and Physician's Assistants. Germantown, Md.: Aspen Systems Corporation, 1977. (Contains "Quality of PA Performance in a Health Maintenance Organization," by J.C. Record, A.V. Hurtdo, and J.E. O'Bannon.)

Lawrence, D. Physician assistants and nurse practitioners: Their impact on health care access, costs, and quality. Health and Medical Care Services Review, 1:1-12, 1978.

Schneller, E. The Physician's Assistant. Lexington, Mass.: D.C. Heath, 1978.

System Sciences Inc. Physician Extenders: Annotated Bibliography. Washington, D.C.: National Center for Health Services Research, 1976. (NTIS No. PB-264-730)

Spitzer, W.O., et al. The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine, 290:251-256, 1974.

JOURNALS AND PERIODICALS

American Journal of Nursing
Business and Editorial Office
10 Columbus Circle
New York, N.Y. 10019

Journal of Continuing Education in Nursing
Ms. Kaye Coraluzzo, Managing Editor
Charles B. Slack, Inc.
600 Grove Road
Thorofare, N.J. 08086

The Nurse Practitioner
Health Sciences Media and Research Services
109 W. Mercer Street
Seattle, Wash. 98119

The PA Journal: A Journal for New Health Practitioners
American Academy of Physician Assistants
2341 Jefferson Davis Highway, Suite 700
Arlington, Va. 22202

Health Practitioner/Physician Assistant
F & F Publications
515 Madison Avenue
New York, N.Y. 10022

APPENDIX D
SAMPLE PROGRAM INSTRUCTIONS

HOW TO APPLY FOR MEDI-CAL

We encourage everyone to apply for Medi-Cal, even if you think that you make "too much money" to qualify. In addition to persons whose income is classified as being on the "poverty level," people whose income is two times this level, or possibly more, can still obtain partial Medi-Cal benefits. This is obtained by paying a sliding scale of fees to Medi-Cal each month to obtain your card. This would be similar to paying a small amount each month for complete health care insurance--and possibly much better coverage, because unlike with most health insurances, there is no deductible to meet or uncovered difference to pay.

The Medi-Cal office is located at 1040 Emeline. If you do not own a car, you can get there by taking bus #8, which runs every hour. 1040 Emeline is just before County Hospital, which is the end of the line for bus #8, before it turns around and retraces its route. The hours of the Medi-Cal office are basically 8:00-5:00 Monday-Friday.

You arrive, go in the door, and check in with the receptionist. She will give you forms to fill out regarding your income, debts, and other economic information to determine if you are eligible for Medi-Cal. In order to verify your income, the social worker will ask you for paycheck stubs or for a receipt if you get paid in cash. It is also a good idea to take along a rent receipt. If you forget to bring these, you will be asked to bring in or mail them to your social worker, usually within about 30 days. You will get a computerized letter reminding you of this also.

After you have filled out your forms, you will turn them in to the receptionist and wait until a social worker is free. She then goes over your forms, has you sign some papers, and can generally tell you on the spot if you qualify.

If you need a card right away (e.g., within the next 2 weeks), tell the social worker: "I have to see a doctor right away, and I have already made an appointment for tomorrow. The doctor will not see me unless I bring my Medi-Cal sticker. Can I please get an emergency card today?" If you need an emergency card, try to arrive at the Medi-Cal office by at least 2 p.m. because it will take you an hour or two to go through all the regular paperwork, and if an emergency card has to be typed up, it will take even longer. You will be handed a temporary card that day. Your next card will be mailed to you.

Each month you have to be recertified for Medi-Cal. A form will be sent to you to fill out. It is important that you fill out and return this form right away, or you will be automatically dropped from the Medi-Cal program and have to go back in to the Medi-Cal office to get back on.

APPENDIX E
SAMPLE MEDICAL HISTORY FORM

WINGSPREAD:
Comprehensive Health Services for Women

CONFIDENTIAL HEALTH HISTORY

A knowledge of your personal health history, including family history and habit patterns, is most important in evaluating your health. Please complete this confidential form as accurately as possible. Approximate dates may be used. The nurse or receptionist will help you if you need assistance.

Name ______________________________ Date ____________

Address ____

Home Phone ________________ Message or Work Phone ________________

Age ____ Date of Birth ____________ Race (Optional) ______________

Person to contact in case of emergency: ____________________________

Phone ____________ Address ____________________ Relationship ________

Who will be responsible for your bill? ____________ Do you have insurance? _____

Name of insurance ________________ Policy # __________ Group # __________

Medi-Cal # ____________ Medicare # ____________ Soc Sec # ______________

PAYMENT OF FEES: Payment for medical services is due on the day of your appointment.

Medi-Cal Patients: We must have your POE sticker for the current month before you can be seen. If you are eligible for Medi-Cal, or think you might be, we have an information sheet which will help you in applying. If you need to be seen right away, you can get a Medi-Cal emergency card on the day you apply.

Medi-Cal/Medicare Patients: We must have your POE sticker for the current month as well as your signature on the Medicare form, and your Medicare number.

Medicare Patients: We must have your Medicare number and your signature on the Medicare form.

Other Insurance: It is the patient's responsibility to bill her own insurance. We will be glad to provide you with the information necessary from the physician in order to submit your insurance claim.

What are the reasons for your present visit? (What is bothering you? -- chest pain, backache, indigestion, etc.?)

____

____

Please list any specific questions you would like to ask our clinician:

____

____

Page 2 ______________

PAST HISTORY

Yes	No	Have you ever had:	For Health Center Use
		Diabetes	
		High blood pressure	
		Heart murmur	
		Heart attack	
		High cholesterol	
		Seizures	
		Stroke	
		Asthma	
		Emphysema	
		Hay fever/sinus	
		Pneumonia	
		Ulcers	
		Hepatitis	
		Thyroid problem	
		Arthritis	
		Anemia	
		Veneral disease	
		Urinary infection	
		Cancer	
		Breast lump	
		Abnormal PAP smear	
		Drug abuse	
		Depression	
		Psychotherapy	
		Uterine infection	
		Kidney disease	
		Tuberculosis	
		Varicose veins	

OTHER MAJOR ILLNESS OR INJURY
(Conditions which lasted for more than a few days or which prevented work or usual activities for several days)

Year	What illness/injury

DRUG ALLERGIES OR SEVERE REACTIONS NONE ☐

Drug	Year	What happened?

DRUGS CURRENTLY TAKEN (Once/month or more) NONE ☐

Drug	How Often?	What for?

STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS: (Check one or more)

☐	Buy medication on my own to treat myself
☐	Never take medications unless prescribed
☐	Usually want a medication prescribed for my illnesses
☐	Willing to try non-drug treatments
☐	Strongly prefer non-drug treatments
☐	Never take drugs or only as last resort

SURGERY AND HOSPITALIZATIONS
(Do not include emergency room visits or childbirth)

Year	Why hospitalized/What surgery

Page 3 ____________

MENSTRUAL HISTORY

Age periods began: ____(age)

Spacing of periods:
(# days from 1st day of
one to 1st day of next) ____days

Duration:
(# days of bleeding) ____days

Amount of flow: ____light
____moderate
____heavy

Severe menstrual cramps: ____yes
____no

Age periods stopped: ____(age)

BIRTH CONTROL

☐ Presently have sexual intercourse
☐ Use birth control currently
Which method?________________
Previous methods:______________
____

☐ Do not use birth control

OBSTETRICAL HISTORY

Number of times pregnant: ____
Number of full term babies: ____
Number of premature babies: ____
Number of abortions/miscarriages: ____
Number of living children: ____
Number of stillborn babies: ____

SMOKING HISTORY

☐ Smoking cigarettes currently
Packs/day ____
Year started____

☐ Stopped smoking cigarettes
Year started____
Year stopped____
Packs/day when smoked____

☐ Smoke pipe or cigars now / in past ☐
☐ Smoke marijuana now / in past ☐
☐ Smoker in household
☐ Never smoked

ALCOHOL USE

☐ Do not drink alcohol currently
☐ Currently drink (even occasionally)
How often: ☐ Less than 1 drink/month
☐ 1 - 3 drinks/month
☐ 1 - 3 drinks/week
☐ 1 - 3 drinks/day

How many drinks do you have at one time?

☐ 1 or 2 drinks
☐ 3 or 4 drinks
☐ 5 or more drinks

(One "drink" = one beer, one glass wine, one shot liquor)

HEALTH RELATED HABITS

Average # hours sleep/night:
☐ 6 or less ☐ 7 ☐ 8 ☐ 9 or more

Do you eat breakfast?
☐ Rarely/sometimes
☐ Daily/almost daily

Do you eat between meals?
☐ Rarely/sometimes
☐ Daily/almost daily

How much exercise do you get?
☐ Often vigorous
☐ Often moderate
☐ Sometimes exercise
☐ Never exercise

How is your current weight?
☐ Underweight ☐ Slightly overweight
☐ Normal ☐ Considerably overwt.

Sexual relations satisfactory? ☐ Yes ☐ No
Would you like to talk with someone about this?

Do you drink coffee:
☐ Yes ☐ No # cups/day ____

List any chemicals, dust fumes, or hazards to which you are exposed in your present occupation:
____

Your current life situation (both work and personal is:
☐ Mildly stressful ☐ Severely stress
☐ Moderately stressful

SYMPTOMS
(Please check if you have or have had any of the following symptoms.)

Symptom	Now	Past	Often	Symptom	Now	Past	Often
Coughing blood				Constipation			
Chest pain when walking				Hemorrhoids			
Chest pain when breathing				Bowel habit change			
Leg pain when walking				Indigestion			
Breast lump				Excess belching			
Black stools				Excess gas			
Vomiting blood				Abdominal pain			
Jaundice (Yellow skin)				Don't tolerate hot weather			
Trouble swallowing				Don't tolerate cold weather			
Trouble walking				Persistant hoarseness			
Fainting spells				Painful urination			
Passing out				Frequent urination			
Convulsions				Involuntary urination			
Tremors				Night urination			
Paralysis				Vaginal discharge			
Change in mole				Painful intercourse			
Non-healing sore				Infertility			
Dizziness				Joint pains			
Headache				Backache			
Double vision				Nervousness			
Ear trouble				Excessive worry			
Nose trouble				Trouble sleeping			
Chronic cough				Trouble with memory			
Coughing phlegm				Trouble concentrating			
Swollen ankles				Depression			
Abnormal bleeding				Crying spells			
Frequent bloody nose				Feelings of worthlessness			
Shortness of breath				Nightmares			
Wheezing				Weakness			
Morning cough				Tiredness on awaking			
Night sweats				Numbness			
Nausea				Skin trouble			
Vomiting				Spotting			
Blood in stools				Spotting after sexual relations			
Diarrhea				Bleeding after menopause			
Swelling				Fluid retention			

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HEALTH MONITORING

What was the year of your last:

Tetanus shot: 19____

Pap smear: 19____

Breast exam by medical practioner: 19____

Mammogram: 19____

TB skin test: 19____

Complete checkup: 19____

CLIENT PLEASE NOTE: After you have finished filling out these forms, please go back and circle those items which are of the most concern to you.

FAMILY HISTORY

For each of the following conditions, check in the appropriate box or boxes if any of your blood relations have had that condition.

	None in family	Spouse	Mother	Father	Children	Sisters	Brothers	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Diabetes											
High blood pressure											
Heart trouble											
Heart attack before 35											
High cholesterol											
Stroke											
Glaucoma											
Breast cancer											
Asthma											
Hayfever											
Tuberculosis											
Kidney Disease											
Mental retardation											
Mental illness											
Suicide											
Alcoholism											
Drug abuse											
Other cancer (specify)*											
A genetic disease											
Living - current age											
Deceased - age at death											

APPENDIX F
LATIN TERMS AND ABBREVIATIONS

The following Latin terms and abbreviations are those that appear most frequently on prescriptions.

Term or Abbreviation	Latin	English
a.a.	ana	of each
a.c.	ante cibos	before meals
ad	ad	to, up to
aqua	aqua	water
b.i.d.	bis in die	twice a day
dentur tales doses	dentur tales doses	give of such doses
d.t.d.	dentur tales doses	give of such doses
gtts	guttae	drops
h.s.	hora somni	at bedtime
non repetatur	non repetatur	do not repeat
o.d.	oculo dextro	in the right eye
o.s.	oculo sinistro	in the left eye
o.u.	oculo utro	each eye
p.c.	post cibos	after meals
p.r.n.	pro re nata	as occasion arises
q.	quaque	every
q.d.	quaque die	every day
q.i.d.	quater in die	4 times a day
q.s.	quantum sufficit	as much as suffices
sig.	signa	write
stat.	statim	immediately
tales doses	tales doses	such doses
t.i.d.	ter in die	3 times a day
u.d.	ut dictum	as told, as directed
ungt.	unguentum	ointment
ut dict.	ut dictum	as told, as directed

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7.

Reproductive Health Concerns for the Treatment of Drug Dependent Women

Josette Mondanaro, M.D.

Research has shown that drug dependent women, particularly heroin addicts living in the street drug culture, are at high risk to develop infections and disorders of the reproductive system. Drugs can affect the reproductive system in many ways, causing irregularities and unwanted pregnancies that often lead to serious health problems. If taken during pregnancy, psychoactive drugs are also likely to affect the fetus. Although congenital abnormalities occur primarily during the early months of pregnancy, some drugs can affect fetal growth, postnatal behavior, and mental performance of the newborn when exposure occurs during later stages of pregnancy (Thornburg and Moore 1976).

This chapter will acquaint the reader with (1) health problems and concerns associated with the reproductive system of the chemically dependent woman and (2) the options and treatment alternatives available to these women. The purpose of this discussion is to increase awareness of, concern for, and attention to women's reproductive health needs. Clinicians who work with chemically dependent women are in a unique position to advance knowledge, promote prevention methods, assure proper testing and evaluation procedures, help women identify and select alternatives (e.g., birth control and treatment protocols), and monitor treatment.

A study by Andersen (1977) found that 43 percent of drug dependent women had gynecological abnormalities at intake and that 56 percent of the women developed such problems during treatment. In Detroit's Hutzel Hospital Pregnant Drug Addict Program, 81 percent of the women developed vaginitis and 24 percent had abnormal Pap tests during treatment (Stryker 1979). Physicians, nurse practitioners, and physician assistants may not be aware of many of the special health needs of drug dependent women. Therefore, counselors should share the information in this chapter not only with clients, but also with health practitioners who are treating clients. Counselors should also monitor health services to assure that the client has not inadvertently been prescribed a drug that is contraindicated. Drug dependency programs that serve women are urged to design client training programs and health seminars on these issues. If the material is presented in clear and simple terms, women will become better informed about their own health needs and become less dependent on health care providers. Training programs can also address therapeutic issues as women begin to deal with pregnancy planning, prostitution, birth control, rape, venereal disease, and abortion.

The following topics related to women's health will be discussed in this chapter:

- Establishing gynecological services;
- Resistance to medical treatment;
- Infertility;
- Pelvic inflammatory disease;
- Planned pregnancies;
- Birth control: Concerns for drug dependent women;
- Unplanned pregnancies;
- Infections of the reproductive tract; and
- Cervical cancer.

The counselor's roles in working with drug dependent women and health professionals are discussed in detail in chapter 6. Topics highlighted here represent specific areas in which the chemically dependent woman will have unique treatment problems.

ESTABLISHING GYNECOLOGICAL SERVICES

Gynecological services, including family planning, are an integral part of the initial intake exam for drug dependent women. Clinical experience indicates that these services are also needed on an ongoing basis while women are in treatment. It is hoped that the drug treatment program will contract with a health provider who can perform the entire general physical and gynecological exam at the same time. If this cannot be arranged, the program will have to locate a resource for gynecological care. It should be noted that many family planning clinics give only birth control exams and advice. In this situation, should a woman need treatment for vaginitis, sexually transmitted diseases, and other gynecological difficulties, she would have to go to yet another health care provider. This fragmentation of services is not only costly and inconvenient, but may lead to an error in treatment. For example, one chemically dependent woman was being treated for hepatitis by her general practitioner while her family planning clinic dispensed birth control pills to her. The family planning clinic did not know that the woman had hepatitis. Birth control pills are contraindicated in clients who have active liver infections such as acute infectious mononucleosis or hepatitis.

To avoid this type of problem, programs should try to work with health care providers who can deliver comprehensive primary medical care. If this is not possible, the second best situation is a provider of all gynecological services including family planning.

The third solution would be to have separate providers for general medical care, gynecology, and family planning. Chapter 6 outlines approaches to locating and establishing comprehensive health care services. Should the program need to establish separate or backup gynecological and family planning services, the following resources are typically available in most communities:

- Private practitioners: gynecologists or family practitioners;
- Family planning clinics of the county or city public health departments;
- Obstetrical/gynecological outpatient departments of teaching hospitals, city or county hospitals, and private hospitals;
- Planned Parenthood clinics; and
- Women's Health clinics.

The functions of health care coordination and health advocacy become even more essential when the client must see multiple providers. All the medical forms discussed in chapter 6 can be used with gynecological and family planning service providers. The treatment program is still responsible for making appropriate referrals, assessing attendance at medical appointments, following through on medical treatment--assuring compliance, and assuring that, where necessary, the client keeps the followup appointment. The health coordinator, program nurse, or counselor should make sure that the client understands the diagnosis and prescribed treatment. In one clinic the chemically dependent woman returned to the physician, saying that she could not finish the prescribed treatment for vaginitis because the pills gave her a stomach ache. The medication was vaginal suppositories, which were supposed to be inserted vaginally, not swallowed. Had the program's counselor or nurse discussed this treatment with the client as soon as she returned from the physician's office, the misunderstanding and stomach pain could have been avoided.

Programs should not underestimate the amount of time and effort it will take to communicate these delicate medical issues to their clients.

Once the formal linkages are established, it will be important for the drug treatment staff to educate the health providers as to the special needs of drug dependent women. Conversely, staff from family planning clinics might be invited to give presentations, participate in the training of treatment program staff, and provide information to client groups. Family planning educators and counselors can discuss the anatomy and physiology of reproduction, the advantages and disadvantages of contraceptive methods, and basic education in human sexuality. Treatment programs interested in family planning training resources could contact the family planning institutes in their respective regions (see appendix A).

RESISTANT TO MEDICAL TREATMENT

Drug dependent women may be reluctant to discuss family planning. Considering the inadequate and often inappropriate gynecological care many of these women have received, this resistance is understandable. For instance, a physician in a correctional institution refused to do pelvic exams, so every woman who complained of a vaginal discharge was given the same type of vaginal cream regardless of the true cause of her discharge. Another physician, who believed that heroin dependent women should not have children, recommended removal of a woman's fallopian tubes and uterus when she developed an infection of the fallopian tubes. Most physicians treating a general population would attempt to save a patient's uterus and fallopian tubes by administering oral antibiotics or administering antibiotics intravenously in a hospital.

A NIDA-supported study (Ryan 1978) of 10 U.S. hospitals indicated that obstetricians and gynecologists find it difficult to treat drug dependent women. For example, the study showed the following:

- Obstetricians generally find that it is more difficult to perform pelvic examinations for pregnant addicts than it is for drug-free women. They report that addicted women find the examination more painful, either because they have a low pain threshold or because they are more likely to have infections in the pelvic area that cause discomfort during the examination. Consequently, it was concluded that special care and patience are necessary during examination of pregnant addicts.

- Six of seven obstetric staffs indicated that care of the pregnant addict takes longer to deliver than for comparable drug-free women.

- Staff at all of the hospitals visited indicated that some of the resident obstetricians are openly hostile to and clearly dislike pregnant addicts. In two instances, obstetricians said they believed all addicts should be sterilized.

Women have experienced painful and degrading pelvic exams from physicians who have biased attitudes toward prostitutes and heroin addicts. Some physicians are motivated more by their moralistic attitudes than by good medical practice (Cooperstock 1971). These prior bad experiences make it imperative that the counselor or the nursing staff prepare the client for gynecological exams and discussions of birth control. Selecting a supportive health care provider and having a health advocate accompany the client to the medical exam can help alleviate the client's fears (see chapter 6).

INFERTILITY

Heroin-dependent women often assume that they are infertile and therefore do not practice birth control (Blinick et al. 1969). This belief is probably due to the fact that more than two-thirds of heroin dependent women experience a decrease in the frequency or a total absence of their menses (Finnegan 1979). Larger doses of opiates appear to suppress ovulation by decreasing the production or release of the hormones (gonadotropins) responsible for initiating ovulation (Gaulden et al. 1964). The heroin addict's lack of menses has been directly attributable either to the heroin itself or to the addict's lifestyle (Santen et al. 1975; Wallach et al. 1969). Heroin decreases ovulation but may not stop ovulation altogether. Heroin use, therefore, is not a particularly safe or effective method of birth control. It is important to stress that not having a period (amenorrhea) does not mean that the woman is not ovulating. Unfortunately, many women believe that so long as they do not have periods, they cannot get pregnant. This is not true.

After months of not menstruating or ovulating, a heroin dependent woman may ovulate without menstruating. At this time she can become pregnant. Once a woman becomes drug free or is placed on methadone maintenance, her body will generally readjust and she will begin to ovulate more regularly. In fact, her body may readjust long before she is willing or able to cope with the responsibilities of birth control.

Other drugs, such as the major tranquilizers, can suppress the normal hormones and imitate a state of pregnancy. Chronic use of these drugs may cause lactation (production of breast milk) as well as temporary cessation of periods.

There is growing clinical evidence that chronic daily use of marijuana suppresses ovulation in some women. Rapid or extreme weight loss secondary to anorexia nervosa or use of drugs such as amphetamines and cocaine can also cause a woman to stop menstruating. Clinicians should remember that women's reproductive hormones are under direct control of the higher brain centers (hypothalamus). Events and chemicals that suppress brain functioning may ultimately have an effect on this sensitive hormonal system. Many events in a woman's life can cause amenorrhea. "Illness, physical or mental stress, travel, a new job, rapid or extreme weight loss, beginning college, entering prison, and many other events . . . can lead to a loss of menses" (Stewart et al. 1979).

Clients should be informed at the start of treatment that they probably are not infertile and that they most likely will start having periods. It is important to stress that they should not wait until they menstruate before seeking protection from unwanted pregnancies, because they could ovulate without menstruating. Health practitioners should be apprised of the client's drug history and other stressful events that may have precipitated the loss of ovulation or menses.

PELVIC INFLAMMATORY DISEASE (PID)

Infection in the fallopian tubes, followed by chronic scarring (acute, subacute, and chronic pelvic inflammatory disease), is another reason that drug dependent women often believe they are infertile. Because the lifestyle of the heroin-dependent woman often puts her at high risk for contracting vaginitis, gonorrhea, and ultimately pelvic inflammatory disease (PID), and because the presence of PID can have devastating effects on a woman's health and ability to conceive, counselors are urged to become familiar with the following facts concerning PID (Hatcher et al. 1980):

- About 12 to 17 percent of women exposed to gonorrhea will develop pelvic inflammatory disease.

- Once a woman has had gonococcal PID, she is more susceptible to subsequent infections by other bacteria.

- A woman is at an increased risk of developing PID even if she has had no prior episode of gonococcal infection:

    - Following delivery (postpartum);
    - Following a therapeutic abortion; or
    - While using an intrauterine device.

It is believed that 80 percent of all acute cases of gonorrhea go undetected because gonorrhea is often asymptomatic in women (Lauersen and Whitney 1977). The bacterium that causes gonorrhea can spread and infect the fallopian tubes. If this condition goes untreated or undertreated, the infection can ultimately cause the proliferation of fibrous bands of scar tissue in the tubes. As the scar tissue contracts, it closes off the tubes. If the very tips of the fallopian tubes (the fimbriae) are destroyed by the infection, or if the tubes are contracted shut, the egg cannot move freely down the tube to the uterus. This situation increases the chances of a tubal (ectopic) pregnancy. The incidence of having a tubal pregnancy is 1 in 25 pregnancies following PID (Hatcher et al. 1980). In a tubal pregnancy, the fertilized egg fails to move into the uterus and instead remains in the tube and begins to implant in the wall, a potentially dangerous situation.

The incidence of sterilization due to the closing off of the fallopian tubes increases with the number of PID episodes a woman has experienced. The chances of becoming sterile are ". . . approximately one in ten after one episode of PID, one in three after two episodes of PID, and three in four after three episodes of PID" (Hatcher et al. 1980).

Although many drug dependent women have had pelvic inflammatory disease, most have not received thorough fertility workups. A woman may have been told that PID may make her sterile. The combination of not ovulating because of heroin use and some scarring secondary to a tubal infection may make it difficult for a woman to conceive; however, once she is drug free or on methadone, she will begin ovulating. Although the scarring may make it more difficult for her to conceive, conception is not impossible. Therefore, when women say that they are sterile because of past tubal infections, it is important to evaluate whether or not a definitive diagnosis was ever made. Clinical records of special tests should show if an adequate evaluation was carried out. If the woman has not received the proper testing, she should be urged to do so. She can receive this testing through a private gynecologist or a family planning clinic at a local public hospital. Proper testing and a definitive diagnosis are essential if a drug dependent woman is to make responsible decisions affecting her reproductive health.

PLANNED PREGNANCIES

If a woman in treatment wants to become pregnant, counselors should discuss the steps she and her partner should take to assure a healthy environment for the fetus. Counselors should stress disease prevention and health promotion. Smoking, drinking alcohol, and using drugs have all been implicated in causing increased fetal morbidity and mortality. There is growing evidence that the father's drug and alcohol intake will affect the quality of the sperm, which in turn will affect the fetus. Drug dependency has a negative effect on a woman's health in many ways, but the results of poor nutrition may prove to be the most costly for both mother and child.

While on heroin, women typically lose weight and the intrauterine growth of the fetus is slowed down. Many people erroneously believe that the mother's weight loss and the inability of the fetus to thrive are secondary to lifestyle issues such as living on the streets, not having enough money to buy food, and repeated exposure to infections. Certainly these take their toll, but the greatest impact is from the heroin itself. Use of heroin causes nausea and decreased appetite. Heroin addicts typically decrease their intake of food and lose weight because of these uncomfortable feelings. Knowing this, counseling personnel in all treatment programs should approach their pregnant clients' use of heroin in an aggressive manner.

One methadone program in California increases its monitoring of urines to three times a week on all pregnant women. When programs understand the deleterious effect heroin has on pregnancy, they are more prone to respond quickly and appropriately to the client's continued use of heroin.

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Many heroin addicted women enter treatment malnourished and suffering from anemia. Since pregnancy is a stressful time for a woman's body, her physical condition will get worse during pregnancy if proper preventive measures and treatment are not instituted. Addicts also have difficulty with their teeth and pregnancy can add significantly to this problem as the growing fetus uses calcium and other nutrients from the mother's body. Therefore, if a woman begins pregnancy with her teeth in a state of disrepair, the pregnancy is likely to exacerbate her dental problems. Out of genuine concern for the health and well-being of the woman, it is important to stress interest in helping her get stronger and healthier before becoming pregnant.

This is a delicate area. There are those who would want to get involved with eugenics--the concept of trying to improve a race by controlling breeding. Drug treatment programs see a disproportionate number of poor people and people of color, especially black and brown people. These are the people who traditionally have been the target of population control and eugenics. The fact that heroin dependent individuals are often viewed as criminals and deviant may also put them at a high risk for being seen as inappropriate breeders by those who believe in eugenics.

It is not a drug program's place to decide who should or should not get pregnant. Population control and eugenics cannot be the hidden agenda behind pregnancy and birth control information. It will take constant vigilance in the form of individual and group self-evaluation and discussions to explore the motives that determine programs' attitudes and actions in these areas.

Besides the issue of population control, it is also possible for counselors to fall into the baby trap. The drug dependent woman may place all her desire to become rehabilitated on having a baby. Counselors, eager for the client to demonstrate motivation for treatment, may collude with the woman in placing too much emphasis on possible future pregnancies. The counselor should keep in mind that the motivations for having children are never simple, especially for women who may have been abused and neglected in their own families. Since many of these women have neglected their own needs, focusing on future pregnancies may be another way of avoiding their own problems and needs.

While the woman is voicing her own concerns regarding future pregnancies, she may misinterpret the counselor's concerns. The counselor may believe she or he is helping the woman prepare for a child, while the woman may be getting a different message--that her own health is not valued. She may hear an old message reinforced--that she is useless, while her child-to-be is quite valuable. It is important for counselors to show concern for the woman's health, whether she plans to become pregnant or not. She needs to feel valued as an individual, not simply as an adjunct to her unborn child, her husband, or anyone else.

It requires skill and sensitivity for counselors to share positive concerns about the woman's health without appearing to be suggesting that she should not have children. It also takes skill to demonstrate concern for the woman's health without appearing to be concerned with the woman only because of her childbearing role.

Program staff members should let the woman known that they appreciate the stress she has experienced while using drugs and that they would like to work with her to regain her health and sense of well-being. The following steps are suggested for a woman who wishes to become pregnant but who has been chemically dependent:

- Obtain a comprehensive medical exam and resolve identified medical problems.
- Receive a complete dental checkup and resolve all dental problems.
- Stop alcohol and drug use and cigarette smoking for 6 months prior to attempting to conceive.
- Clear up all vaginal infections--especially trichomonas vaginitis and gonorrhea--prior to conceiving.
- Make sure the Pap test for cervical cancer is normal.
- Evaluate personal stress level and actively try to decrease stresses while acquiring new stress management skills.
- Evaluate nutritional status and initiate a healthy diet.
- Resolve anemia if present.
- Explore birth control methods. Select and use an acceptable method during these 6 months.
- Commit partner to health maintenance prior to conception.

BIRTH CONTROL: CONCERNS FOR DRUG DEPENDENT WOMEN

Many resources are available that outline family planning. Hatcher et al. (1980) provide an excellent reference book for counselors, which describes the effectiveness rates, side effects, and contraindications of the different types of birth control. Two references that both counselors and clients could use are My Body, My Health (Stewart et al. 1979) and Our Bodies, Our Selves (Boston Women's Health Collective 1976). In addition, the Bureau of Community Health Services offers a number of excellent references on family planning (appendix B).

Topics discussed in this section include information that is specific to the needs of drug dependent women and is not readily available in other sources on family planning. Fertility awareness methods (such as keeping basal body temperature and observing vaginal mucous which changes at ovulation) are not discussed here because they may not pose any unique hazard for drug dependent women.

INTRAUTERINE DEVICES

For some drug dependent women who have experienced difficulty with structuring their days and caring for their bodies, the intrauterine device (IUD) may appear to be an easy, carefree form of birth control. However, problems such as the prevalence of pelvic inflammatory disease among heroin dependent women may render this form of birth control unsuitable. The following is a partial list of contraindications to IUD insertion (Hatcher et al. 1980):

- Absolute contraindication
    1. Active pelvic infection, including known and suspected gonorrhea.
- Strong relative contraindications
    1. Recent or recurrent pelvic infection.
    2. History of ectopic pregnancy.
    3. Single episode of pelvic infection if patient desires subsequent pregnancy.
- Other relative contraindications
    1. Anemia.
    2. Impaired ability to check for danger signals (psychological or intellectual).
    3. Inability to check for IUD strings.
    4. Multiple sexual partners (greater risk of future infections).
    5. Past history of gonorrhea.
    6. Concern for future fertility.

Pelvic inflammatory diseases are ". . . the most serious complications related to IUD use, accounting for a majority of IUD-related deaths and hospitalizations" (Hatcher et al. 1980). A followup study found that 26 of 100 women developed PID during the first year following IUD insertion at a municipal family planning clinic. If a woman is concerned about future pregnancies and has had pelvic infections, the IUD is not an appropriate choice for birth control.

Vaginal discharge is an early warning of more serious problems relating to IUD use (Hatcher et al. 1980). Because many drug dependent women have learned to accept vaginal discharge as a normal event, they must become more aware of abnormal discharges if they use an IUD. When a woman enters treatment with an IUD in place, the counselor should ask what type of IUD she has, when she was examined last, and if she has had pelvic inflammatory disease or gonorrhea in the past. Once the woman detoxifies from drugs, she will be in a better position to give a more accurate history and to receive information regarding signs she should look for.

Both the counselor and the client should become familiar with the early IUD danger signals. A physician should be contacted if a woman develops any of these signals (Hatcher et al. 1980):

- Period late or no period;
- Abdominal pain;
- Increased temperature, fever, chills;
- Nasty foul-smelling or yellow or green discharge; or
- Spotting, bleeding between periods, heavy periods, or clots.

Note that the first letters of these warning signals spell out PAINS.

BIRTH CONTROL PILLS

Although physicians and family planning clinics continue to recommend the pill as ". . . the most effective way to prevent pregnancies . . .," others (Lauersen and Whitney 1977) take a more cautious stance and point out some of the potential hazards. Drug dependent women who have liver disease secondary to excessive alcohol intake or to hepatitis should not take birth control pills. Women with chronic liver disease of any type may develop more significant abnormalities in liver function while using birth control pills and during pregnancy. For these women, it is imperative to prevent pregnancy until the liver is healed and to do this with forms of birth control other than the pill.

Counselors should be familiar with the fact that drugs that alter liver function may decrease the effectiveness of birth control pills. Some of the drugs that alter liver function are tranquilizers, sedative/hypnotics, ampicillin, sulfa drugs, allergy pills, Dilantin for epilepsy, some high blood pressure medications, and some antidepressants (Stewart et al. 1979). Hatcher et al. (1980)

report that only 45 to 75 percent of any group of women who initiate pill use will continue to use them for 1 year. Therefore, women who start taking the pill should also be familiar with a second method of contraception. The minor side effects of the pill include (Hatcher et al. 1980; Lauersen and Whitney 1977):

- Nausea and dizziness;
- Headaches;
- Cyclic weight gain;
- Breast fullness and tenderness;
- Fluid retention in eyes, causing contact lenses not to fit;
- Edema in legs, causing leg pain and cramps;
- Monilia--yeast vaginitis; and
- Spotting or breakthrough bleeding.

Although these side effects are often minor, the discomfort they cause makes the pill unacceptable for many. Major side effects are those that dramatically disrupt normal functioning. One major side effect that has received widespread publicity is the increased incidence of thromboembolic disease with pill use. This disease is caused by the abnormal formation of a clot in a vein. The incidence of deep vein thrombosis increases dramatically from 20 cases (for non-pill-taking women) to 100 cases (for pill-takers) per 100,000 women per year (Lauersen and Whitney 1977). Smoking is a ". . . potent factor in predisposing pill users to cerebral thrombosis," a stroke caused by a clot in the brain. The incidence of cerebral thrombosis is increased from 10 to 40 cases per 100,000 women per year with pill use.

The incidence of heart attacks (myocardial infarctions), high blood pressure, gall bladder disease, and liver tumors is greater in women who use birth control pills. There is growing evidence that if birth control pills are taken during the first months of pregnancy, congenital malformations can occur in the fetus (Lauersen and Whitney 1977).

Depression is a side effect reported by 13 percent of pill users (Lauersen and Whitney 1977). It is believed that a pill-induced depletion in the level of vitamin B_6 adds to the depression and that vitamin supplements with B_6 can decrease depression. Water retention due to the pill also appears to increase depression. Many women report that they were not aware of how depressed they were until they stopped taking the pill. Drug dependent women who are prone to depression may not be appropriate candidates for the estrogen-containing birth control pill. Also, women who enter treatment using the pill should be urged to take a break from the pill for at least 3 months every 2 to 3 years so that any suppression in normal hormones can be detected early (Stewart et al. 1979). During this break it may become apparent that depression is in part related to pill use.

The following is a list of contraindications to estrogen-containing birth control bills (Hatcher et al. 1980):

- Absolute contraindications

  1. Thromboembolic disorder (or history thereof);
  2. Cerebrovascular accident (or history thereof);
  3. Coronary artery disease (or history thereof);
  4. Impaired liver function;
  5. Hepatic adenoma (or history thereof);
  6. Malignancy (cancer) of breast or reproductive system (or history thereof); or
  7. Pregnancy.

- Strong relative contraindications

  1. Termination of term pregnancy within past 10 to 14 days;
  2. Severe vascular or migraine headaches;
  3. Hypertension with resting diastolic BP of 110 or greater;
  4. Diabetes, prediabetes, or a strong family history of diabetes;
  5. Gall bladder disease, including cholecystectomy;
  6. Previous gall bladder problem during pregnancy;
  7. Infectious mononucleosis, acute phase;
  8. Sickle cell disease or sickle C disease;
  9. Undiagnosed, abnormal vaginal bleeding;
  10. Elective surgery planned in next 4 weeks;
  11. Long-leg casts or major injury to lower leg;
  12. Over age 35 to 40; or

13. Fibrocystic breast disease and breast fibroadenomas.

- Other relative contraindications

The following may contraindicate initiation of pills:

1. Failure to have established regular menstrual cycles;
2. Cardiac or renal disease (or history thereof);
3. History of heavy smoking;
4. Conditions likely to make patient unreliable at following instructions, such as mental retardation, major psychiatric problems, history of alcoholism, history of repeatedly taking pills incorrectly, or young age;
5. Lactation (however, oral contraceptives may be initiated as weaning begins and may be an aid in decreasing the flow of milk); or
6. Patient profile suggestive of anovulation and infertility problems: late onset of menses and very irregular, painless menses.

Counselors working with clients who are using pills should observe carefully and check with clients periodically for worsening or improvement of problems:

1. Depression;
2. Hypertension with resting diastolic BP of 90-100;
3. Chloasma or hair loss related to pregnancy (or history thereof);
4. Asthma;
5. Epilepsy;
6. Uterine fibroid tumors;
7. Acne; or
8. Varicose veins.

Liver disease, other drug use, smoking, and vein problems secondary to shooting heroin may put the heroin addict at an increased risk of developing problems with the estrogen-containing birth control pills.

If, after reviewing the potential side effects and the contraindications, a woman and her physician decide that the pill is an appropriate choice for her, she should receive a moderately low estrogen dose because the estrogen might cause most of the side effects. If a woman does well at this dose, she can be dropped to a low-dose estrogen pill.

Women who are on the pill should learn the six danger signs of its use (Stewart et al. 1979):

- Chest pain;
- Pain in calf (leg);
- Severe headache;
- Vision changes;
- Breast lump; or
- Severe depression.

MINIPILLS

The minipill contains no estrogen and has only progestin. The absolute contraindications to the use of estrogen-containing birth control pills stated above apply also to the minipill. Aside from these, the progestin-only pills should be avoided for women with the following problems (Hatcher et al. 1980):

- Prediabetes;
- Undiagnosed genital bleeding;
- Acute infectious mononucleosis;
- Irregular periods; or
- Past history of ectopic pregnancies.

Although the minipill is probably safer than the combined pill (since it contains no estrogen), it has two drawbacks that may decrease its usefulness for drug dependent women. First, the minipill must be taken without fail every day. If one day is missed and the woman takes two pills the following day, she may not be protected. She and her partner should use a backup birth control method along with the minipill until her next menstrual period. The second disadvantage is the increased frequency of ectopic (tubal) pregnancies experienced with the minipill. If a woman has had repeated bouts of PID or a previous ectopic pregnancy, she should not take this pill.

For a recovered woman who has demonstrated the ability to take responsibility for her health and who does not have any of the problems that contraindicate this method, the minipill may prove to be a safer method of birth control than the estrogen-containing pills. The counselor can help the client create a ritual that will help her remember to take her pills daily. For example, women on methadone programs can arrange to take their pills each day when they receive their methadone. Other techniques women use to remember to take their pills include the following:

- Crossing off dates on a calendar;

- Taking before brushing teeth in morning or evening; or
- Leaving near alarm clock and taking on waking up every morning.

DEPO-PROVERA ("THE SHOT")

Depo-Provera is a long-acting derivative of progesterone (medroxyprogesterine acetate) that is currently marketed in 70 countries (Hatcher et al. 1980). The use of Depo-Provera for contraception is being investigated by the Food and Drug Administration (FDA) (Hatcher et al. 1980). One injection of Depo-Provera provides contraceptive protection for 3 months.

Some of the side effects of Depo-Provera include excessive weight gain, depression, headaches, decreased libido, and allergic reactions. The weight gain appears to be cumulative, with women experiencing a steady increase in weight the longer they are on the shot. In one study, women gained up to 24 pounds each after being on long-acting progestins for approximately 5 years (Hatcher et al. 1980). Since methadone appears to affect carbohydrate metabolism, and the effect of Depo-Provera on carbohydrate metabolism is just being studied, women being maintained on methadone probably should not be put on Depo-Provera until the combined effects of the two drugs are adequately studied.

One of the major disadvantages of the progesterone-only contraceptive methods is that they have not been around long enough for the effects of long-term use to be thoroughly evaluated. One must be cautious of new products bearing promises of effective results and few side effects.

BARRIER METHODS

Diaphragms, condoms, and spermicidal agents work by creating a barrier between the sperm and the cervical opening and by killing the sperm. These methods have the least dangerous side effects and the fewest contraindications of all contraceptive methods besides the fertility awareness methods. One major disadvantage is that barrier methods depend heavily on the reliability of the user. Sometimes people find these methods unsatisfactory because they require preplanning and may interrupt spontaneity. But as women and men take responsibility for their own reproductive health and become more aware of the adverse effects of the pill and IUDs, the barrier methods are gaining popularity. Two major advantages of the barrier methods for drug dependent women who have sexual relations with multiple partners are possible protection from cervical cancer and from sexually transmitted diseases (Stewart et al. 1979).

The diaphragm traditionally has been considered less effective than the pill or an IUD. A recent survey of 2,175 women followed for 2 years demonstrated that under the right conditions the diaphragm has a user effectiveness of 98 percent (Hatcher et al. 1980). It is believed that the impressive results of this study were due to a comprehensive education program and careful fitting of the diaphragms. Not only did each woman practice inserting her diaphragm at the time of the fitting, but each woman also returned to the clinic 1 week later to be rechecked for proper fit and proper insertion technique (Hatcher et al. 1980).

The diaphragm must be used with either a spermicidal cream or jelly. It is believed that the major contraceptive benefit of the diaphragm is as a holder of the spermicidal substance.

Condoms provide protection against venereal disease as well as conception. Condoms should also be used with a spermicidal agent such as foam to assure maximum protection.

With proper instructions, a motivated and responsible drug dependent woman can use barrier methods safely and effectively. Women whose lives are in disarray and who still are experiencing difficulty in assuming control may find these methods difficult to use in a consistent and reliable manner.

VOLUNTARY STERILIZATION

Tubal ligations in women and vasectomies in men are increasing in popularity as safe and effective methods of permanent birth control. While research continues on reversible vasectomies and tubal ligations, for all practical purposes these procedures are considered irreversible at this time. Although both procedures are fairly simple, many clients will lack accurate information regarding their effects.

There are currently five basic procedures used for tubal ligations. In My Body, My Health, Stewart and associates (1979) give an excellent description of the sterilization procedures with clearly illustrated drawings.

The procedure selected often depends on the gynecologist's preferences and experience as well as the client's condition. For example, a drug dependent woman who has had repeated bouts of PID with much scarring of her tubes would not be a good candidate for the vaginal or minilaparotomy tubal ligations. These procedures necessitate easy access to movable fallopian tubes. Also, drug dependent women who are 20 percent above their ideal weight are not good risks for the minilaparotomy. Because the incision is very small in this procedure, adipose (fat) tissue would interfere with proper visualization of the tubes. The vaginal tubal ligation has a higher complication rate primarily because of the increase in infection experienced with this technique. Drug dependent women who have had multiple bouts of vaginitis and cervicitis may wish to choose another type of tubal ligation.

Counselors should be familiar with the danger signs following a tubal ligation. The physician should be called if the client develops any of the following symptoms (Hatcher et al. 1980; Stewart et al. 1979):

- Fever greater than 100°;
- Fainting spells;
- Chest pain, cough, or shortness of breath;
- Pain not relieved by aspirin or that lasts longer than 12 hours; or
- Bleeding from incision site or vagina.

UNPLANNED PREGNANCIES

Because they often do not menstruate, heroin dependent women are typically unable to diagnose early pregnancy. In addition to adjusting to the absence of periods, the heroin dependent woman may not be paying close attention to other bodily changes because of her heroin use and lifestyle. For instance, the dependent woman may not be able to differentiate morning sickness from drug sickness. Also, women gain much less weight during pregnancy while they are actively using heroin. It is common to find a drug dependent woman 5 or more months pregnant who does not appear to be pregnant. Sometimes a heroin dependent woman will seek medical care for indigestion and a rumbling feeling in her abdomen, only to find that she is 5 months pregnant. Women dependent on other drugs are not as prone to missing periods but may be as out of touch with changes in their bodies as heroin dependent women are.

In failing to diagnose pregnancy, drug dependent women may also be exercising a certain degree of denial. Coming to terms with the pregnancy can be overwhelming for a woman who does not have control of her life. Counselors should be familiar with the various community resources, sources of information, and general procedures available to women who seek abortions. The drug counselor should not attempt to make any value judgments regarding the appropriateness of an abortion, but instead make a referral to a counselor or health care provider who is trained to provide the counseling needed.

Every woman should have the opportunity to talk with a trained counselor about her decision to have an abortion before the procedure takes place. This should not cause any delay that might increase the risk of complications. Beresford's (1977) self-instructional manual for short-term counseling in sexual and reproductive health provides basic principles and guidelines for counselors involved in this area.

The World Health Organization (1979) has produced a booklet containing basic information and guidelines for individuals providing services to women seeking induced abortion. The Family Planning Evaluation Division (FPED) of the Center for Disease Control (CDC) maintains a library of reprints of staff-generated articles (appendix C).

The decision on whether to seek an abortion is an individual one and will depend on the woman's beliefs, her relationship with her partner and her family, the possible alternatives, and the prevailing social pressures. For the drug dependent woman, ignorance may be the major constraint. She may not know for sure whether she is pregnant, and late detection of pregnancy can decrease her options.

Chemically dependent women experience the following three areas of special needs when considering abortions:

- Early detection of pregnancy;
- Anesthesia, pain control, and addiction; and
- Prevention of postabortion complications.

EARLY DETECTION OF PREGNANCY

Drug treatment programs should make sure that drug dependent women are screened for pregnancy during intake. The availability of accessible and acceptable ongoing gynecological services will also assist in the early detection of pregnancy. Counselors should keep in mind that should the client decide to maintain the pregnancy, early detection will also enable her to receive early prenatal care.

For those women who elect to have a therapeutic abortion, early detection and intervention are associated with a decreased risk. The more advanced the pregnancy, the more difficult the abortion procedure becomes. The Center for Disease Control reports 1.7 deaths per 100,000 dilatation and evacuation abortions, whereas it reports 15.5 deaths per 100,000 women for second trimester intrauterine instillation abortions (Hatcher et al. 1980).

ANESTHESIA, PAIN CONTROL, AND ADDICTION

For abortions, as well as other surgical procedures, the choice of anesthesia and pain medication is complicated by the presence of drug dependency. The following section will familiarize counselors with the treatment issues. It is imperative that drug treatment programs assume that health care providers are aware of these special concerns.

For women maintained on methadone, the choice of pain medication will usually be the same as that indicated for the general population, with one important exception: Pentazocine (Talwin) should

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never be given to a methadone- or other narcotic-maintained patient because it is both a narcotic agonist (has narcotic effects) and an antagonist. Thus, use of pentazocine will precipitate acute narcotic withdrawal symptoms.

Methadone-maintained patients may require larger or more frequent doses of medication when a narcotic is to be used for relief of pain because of the high degree of tolerance and cross-tolerance they develop during chronic methadone treatment. Short-acting narcotics such as Demerol or morphine should be used for pain relief.

Usual types of anesthesia may be administered to patients maintained on methadone. Whenever a methadone patient is to undergo surgery or have any other procedure performed that requires that no food or water be taken for a certain period, methadone should be given parenterally (by subcutaneous injection) on the day of the procedure in two divided doses. Patients in methadone maintenance treatment experience pain just as other persons do. Thus, methadone-maintained pregnant women will require management for pain during therapeutic abortions, normal or instrumental vaginal delivery, or during and following caesarean section. As mentioned above, the doses and frequency of doses of any narcotic used may have to be greater than normal because of the degree of tolerance developed. Medications for relief of pain should not be withheld because a woman is receiving methadone maintenance treatment. Physicians performing surgical techniques may be unfamiliar with these factors. The program physician or counselor must make sure that the physician performing surgery is told about these facts.

The medical clinic may decide to give a client an increased dose of pain medication because of tolerance developed. Although an increase in Demerol may have been agreed to, the client still might use other drugs prior to the surgery. If a woman is still using heroin and is on methadone, an overdose is possible. If the client arrives for surgery intoxicated, the counselor should inform the nurses and the physician in charge. The presurgical doses of Demerol should be adjusted depending on the client's condition.

PREVENTION OF POSTABORTION COMPLICATIONS

Infection, the most common postabortion problem, can be reduced by taking the following precautions (Hatcher et al. 1980):

- Preabortion gonorrhea screening and treatment;
- Treating severe cervicitis (infection of the cervix) prior to the abortion; and
- Insuring complete emptying of the uterus.

Infections are recognized by cramping, fever, discharge, and pelvic discomfort (Hatcher et al. 1980; Stewart et al. 1979).

The counselor should make sure that the client is aware of these danger signals. The client should also have the telephone number of the physician or clinic that performed the abortion. There should be 24-hour coverage with emergency room backup. The client should avoid clinics that do not have physicians on call after abortions. If a woman is experiencing difficulty and cannot contact the clinic or physician, she should go immediately to a hospital emergency room.

RESOURCES

Programs should be aware of the different approaches and the options available locally. Counselors should investigate the various clinics, hospitals, and physicians providing these services. Counselors should visit these clinics and talk with some patients before sending their own clients. Setting up formal working arrangements with the clinics, including inviting a clinic nurse or physician to discuss with program staff the kinds of abortions and how staff members can help in the process, is a good idea.

INFECTIONS OF THE REPRODUCTIVE TRACT

Infections of a woman's reproductive tract are traditionally divided into those that are sexually transmitted (e.g., venereal disease) and those that are not necessarily transmitted through sexual contact (e.g., vaginitis). Sexually transmitted diseases include pubic lice, herpes simplex type II, gonorrhea, syphilis, venereal warts, and trichomonas vaginitis (Catterall 1974; Morton 1972). Chances of contracting a sexually transmitted disease increase when a person has multiple partners or is beginning a new relationship. During these times, drug dependent women should urge their partners to use condoms. The basic rules to avoid infection are as follows:

1. Wash genitals.
2. Inspect genitals and surrounding area for lesions, bumps, blisters, or penile discharge.
3. Have partner wear condoms.
4. Get gonorrhea cultures and blood tests for syphilis every 3 to 6 months.
5. Don't have intercourse if there is pain, itching, sores, or unusual discharge.

Since most acute gonorrhea and syphilis infections go undetected in women, early diagnosis depends on blood tests for syphilis and cultures (oral, vaginal, and rectal) for gonorrhea. Many drug dependent women have learned to live with abnormal discharges; the counselor should not, therefore, wait for the client to complain of discomfort. Physical exams, including pelvic exams with wet mount (see chapter 6), Pap tests, cultures, and blood tests should be performed on all female clients at intake.

Partners will need to be treated if the woman has a sexually transmitted disease. Counselors or health advocates may need to convince the client to comply with the medical regimens. See appendix D for basic information on reproductive tract infections.

A special comment needs to be made regarding syphilis. Individuals who have used heroin often may have what is termed a false positive syphilis test. The screening test for syphilis is the VDRL (Venereal Disease Research Laboratory), which tests for the antibodies to the syphilis-causing organism. If the VDRL is positive, further tests are performed that identify the offending agent. Most pathology laboratories immediately perform these tests when the VDRL is positive. All positive VDRLs should be followed up, and clients should not be told they have syphilis until more specific tests are completed.

Women are more susceptible to reproductive tract infections when their general health is not good and when they are under stress. Chapter 6 explains that drug dependent women typically enter treatment in poor physical health. Multiple partners, poor health, stress, a history of inadequate medical care, and lack of adequate health information all place the drug dependent woman at a high risk of developing these infections.

Although the different reproductive system infections may appear to be similar (discharge, odor, pain, and redness), the treatments vary dramatically. One woman in a drug program was treated for trichomonas. She was found to still have the infection during a followup exam and was treated. Two weeks later she called the doctor to ask for another prescription, claiming that she had trichomonas again. The physician refused to write a prescription without seeing the woman. The physical exam and wet mount slide revealed that the woman now had monilia (yeast) vaginitis and that the trichomonas was cleared up. The treatment for trichomonas is Flagyl. Not only would a third dose of this drug not have cured the woman's monilia, but repeated doses could be harmful to her health.

Drug dependent women, especially those who have been incarcerated and lead a streetwise life, have learned either to live with abnormal vaginal discharges or to use any available vaginal creams, suppositories, or pills to treat vaginitis. Clients must be taught that all discharges are not the same, that positive diagnosis can be made only with pelvic exams and lab tests, and that treatment is specific for each type of infection.

CERVICAL CANCER

Over the past 30 years there has been a sharp decline in the incidence of cervical cancer. Most sources attribute this decline to the use of the Pap test. Although both white and nonwhite women have experienced a decline in incidence of cervical cancer, nonwhite women still have twice the mortality rate of white women. Nonwhite women experience 8.0 and white women 4.1 deaths per 100,000 women (Moore 1980).

Many drug dependent women fall into groups that are at a high risk of developing cervical cancer. Although no specific etiology has been discovered for cervical cancer, the factors that increase a woman's chances of developing cervical cancer include the following (Stewart et al. 1979):

- Starting intercourse at an early age;
- Frequent and multiple sexual partners; and
- Herpes virus or other sexually transmitted diseases.

Drug dependent women who have been prostitutes or who began sexual relations at an early age clearly fall within this at-risk group. Women who fall within this group or who have had a history of abnormal Pap tests, a family history of uterine or cervical cancer, or exposure to diethylstilbesterol (an estrogen) or birth control pills should have Pap tests at least once a year (Moore 1980; Stewart et al. 1979).

Chemically dependent women who are at risk can reduce their chances of getting cervical cancer by

- Having partners use condoms and foam;

- Obtaining frequent Pap tests;

- Having regular checkups for sexually transmitted diseases; and

- Avoiding birth control pills and estrogen replacement therapy during menopause.

Counselors and health advocates should make sure that clients receive a Pap test and that all positive findings are aggressively resolved. If a client has an abnormal Pap, the counselor should make sure that followup appointments are made and kept and that the client understands the procedures. (My Body, My Health [Stewart et al. 1979] clearly explains the entire process of taking and interpreting the Pap.) The client may be reluctant to follow up because she is afraid of what might be found. This fear is understandable. But good counseling techniques, proper information, and a supportive health care provider can help the client cope.

CONCLUSION

Drug dependent women often experience special medical needs in the area of reproductive health. Unfortunately, much of the literature on women's health does not include discussions that specifically address these needs. It is hoped that this chapter will increase program awareness and sensitivity to these central medical issues. Developing the capability to respond to the reproductive health needs of chemically dependent women will inevitably move programs closer to their goals of client recovery.

APPENDIX A
FAMILY PLANNING TRAINING INSTITUTIONS

Region I

JSI Research and Training Institute, Inc.
141 Tremont Street
Boston, MA 02135
(617) 482-9485

Region II

Hemisphere Development Corporation
500 N. Washington Street
Alexandria, VA 22314
(703) 872-1470

Region III

Planned Parenthood Association of Maryland
Family Planning Training Institute
610 North Howard Street
Baltimore, MD 21201
(301) 752-0131

Region IV

Emory University
Hartford Bldg., Room 802
100 Edgewood Avenue, N.E.
Atlanta, GA 30303
(404) 523-1996

Region V

Planned Parenthood of Central Ohio, Inc.
206 East State Street
Columbus, OH 43215
(614) 224-2235

Planned Parenthood of Wisconsin
1135 West State Street
Milwaukee, WI 53233
(414) 271-8181

Indiana Family Health Council, Inc.
21 Beachway Drive, Suite B
Indianapolis, IN 46224
(317) 247-9158

Planned Parenthood Association/Chicago Area
55 East Jackson Boulevard
Chicago, IL 60604
(312) 322-4229

Planned Parenthood of Minnesota
1965 Ford Parkway
St. Paul, MN 55116
(612) 698-2401

Region VI

The Center for Health Training
302 West 15th Street, Suite 200
Austin, TX 78701
(512) 476-8342

Region VII

Development Systems, Inc.
4049 Pennsylvania
Kansas City, MO 64111
(816) 931-4828

Region VIII

Rocky Mountain Planned Parenthood
2030 East 20th Avenue
Denver, CO 80205
(303) 321-2471

Region IX

Center for Health Training
2229 Lombard Street
San Francisco, CA 94123
(415) 929-9100

Region X

Planned Parenthood of Seattle/King County
211 East Madison
Seattle, WA 98112
(206) 447-2371

APPENDIX B
FAMILY PLANNING REFERENCE MATERIAL

Family Planning in Primary Care Settings. GPO #872-855, March 1980. A manual designed to help persons working in primary care settings to deliver family planning services in the broad context of prevention and patient education rather than within a purely medical framework.

Improving Family Planning Services for Teenagers. DHHS Pub. No. (HSA) 81-5628, 1981. A report based on a study of clinics providing family planning services to teenagers. Based on the study results, recommendations are made on how to improve services to teenagers.

Contraception. DHHS Pub. No. (HSA) 80-5659, 1980. A basic self-instructional booklet designed to teach women six methods of preventing pregnancy: oral contraceptive (the pill), intrauterine device (IUD), diaphragm (and contraceptive creams or jellies), condom, contraceptive foam, and natural methods.

Understanding Female Sterilization. DHEW Pub. No. (HSA) 76-16025, 1976. A self-instructional booklet to help individuals learn about female sterilization. Specific attention is given to tubal ligation, the most common method of female sterilization.

Family Planning and Health. DHEW Pub. No. (HSA) 79-5657, 1979. A pamphlet briefly describing the reasons for family planning, health tests that are used, and the importance of such practices in producing healthier children.

Female Physical Examination for Contraception. DHEW Pub. No. (HSA) 80-5609, 1980. A self-instructional booklet to promote understanding of the female physical examination that physicians should do routinely to insure appropriate individual contraceptive use.

The Choice Is Yours. DHEW Pub. No. (HSA) 79-5615, 1979. A booklet that tests readers' basic knowledge and provides facts about various contraceptive methods.

These materials can be obtained free of charge by contacting the National Clearinghouse for Family Planning Information, U.S. Department of Health and Human Services, 5600 Fishers Lane, Rockville, MD 20857.

APPENDIX C

ABORTIONS: RELATED PUBLICATIONS FROM THE CENTER FOR DISEASE CONTROL

Reprints of the following publications may be obtained by writing to FPED, CDC, Atlanta, GA.

Cates, W., Jr. Abortion attitudes of black women. Women and Health, 2:3-9, 1977.

Cates, W., Jr. Evaluating the quality of abortion services by measuring outcomes. Advances in Planned Parenthood, 14:13-30, 1979.

Cates, W., Jr. Late effects of induced abortion. Letter--Journal of Reproductive Medicine, 23:78, 1979.

Cates, W., Jr.; Gold, J.; and Selik, R.M. Regulation of abortion services--for better or worse? New England Journal of Medicine, 301:720-723, 1979.

Cates, W., Jr., and Grimes, D.A. On seeking abortion counseling. Letter--American Journal of Public Health, 67:780-781, 1977.

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Cates, W., Jr.; Grimes, D.A.; Smith, J.C.; and Tyler, C.W., Jr. Safety of abortion. Response--Journal of the American Medical Association, 237:2601-2602, 1977.

Cates, W., Jr.; Grimes, D.A.; and Tyler, C.S., Jr. Safety of legal abortion. Letter--Lancet, 1:198-199, 1980.

Cates, W., Jr.; Schulz, K.R.; and Grimes, D.A. Midtrimester abortion procedures. Letter--American Journal of Obstetrics and Gynecology, 133:934-936, 1979.

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Center for Disease Control. Teenage childbearing and abortion patterns United States, 1977. Morbidity/Mortality Weekly Report, 29:157-159, 1980.

Cheng, M.C.E., and Rochat, R.W. The safety of combined abortion-sterilization procedure. American Journal of Obstetrics and Gynecology, 29:548-552, 1977.

Gold, J., and Cates, W., Jr. Restriction of Federal funds for abortion: 18 months later. American Journal of Public Health, 69:929-930, 1979.

Gold, J.; Cates, W., Jr.; Nelson, M.; Kimball, A.M.; Rochat, R.W.; Chester, D.W.; and Tyler, C.W., Jr. A cluster of septic complications associated with illegal induced abortions. Obstetrics and Gynecology, 56:311-315, 1980.

Grimes, D.A., and Cates, W., Jr. Abortion: Methods and Complications. In: Hafez, E.S.E., ed. Human Reproduction: Conception and Contraception. New York: Harper & Row, 1980. pp. 796-813.

Grimes, D.A., and Cates, W., Jr. Complications from legally-induced abortion: A review. Obstetrical and Gynecological Survey, 34:177-191, 1979.

Grimes, D.A., and Cates, W., Jr. The comparative efficacy and safety of intraamniotic prostaglandin F2a and hypertonic saline for second-trimester abortion--A review and critique. Journal of Reproductive Medicine, 22: 248-254, 1979.

Grimes, D.A.: Schulz, K.F.; Cates, W., Jr.; and Tyler, C.W., Jr. Midtrimester abortions. Response--New England Journal of Medicine, 297:511-512, 1977.

Guidotti, R.J.; Grimes, D.A.; and Cates, W., Jr. Amniotic-fluid embolism and abortion. Letter--Lancet, 2:911-912, 1979.

Ory, H.W. The health effects of fertility control. In: Proceedings of a Symposium on Contraception: Science, Technology, and Application, 1978. Washington, D.C.: National Academy of Sciences, 1979. pp. 110-121.

Rochat, R.W. Abortion, the Bible, and the Christian physician. Christian Medical Society Journal, 7:19-26, 1976.

Rubin, G.L.; Gold, J.; and Cates, W., Jr. Response of low income women and abortion facilities to restriction of public funds for abortion: A study of a large metropolitan area. American Journal of Public Health, 69:948-950, 1979.

Speroff, L.; Cates, W., Jr.; Anderson, G.; and Barr, M. Is there a best way to do midtrimester abortions? (symposium) Contemporary OB/GYN, 13:106-141, 1979.

Tyler, C.W., Jr., and Cates, W., Jr. Legal abortion in the United States: Its effect on the health of women. In: Proceedings of the Pathfinder Fund Conference on New Developments in Fertility Regulation, Airlie, 1976. Boston: Pathfinder Fund, 1976. pp. 143-149.

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APPENDIX D
INFECTIONS OF THE REPRODUCTIVE TRACT

Sexually transmitted disease	Discharge	Symptoms	Tests	Treatment	Treat partners	Prevention	Special comments
Trichomonas vaginitis	Frothy, watery; greenish gray or white	Itching, redness, pain, foul odor	Saline slide	Flagyl	Yes	Condoms	Patient shouldn't drink alcohol when using Flagyl.
Herpes simplex II	May not have discharge.	One or more very painful blisters on vulva or buttocks	Usually diagnosed by signs and symptoms--tests are available, using cultures and smears.	No known cure	No known cure	Condoms	Herpes can be transmitted sexually or may arise spontaneously. Get Pap test every 6 mo. to 1 yr. Herpes may be related to cervical cancer.
Gonorrhea	Yellowish. Can often tell by discharge from partner's penis.	May not have symptoms, discharge, or pain	Culture tests from vagina, rectum, and mouth--take 48 hours to grow.	Penicillin Ampicillin	Yes	Condoms	Gonorrhea can spread to the fallopian tubes and cause PID. Person is contagious until cultures are negative.
Syphilis	May not notice symptoms.	Chancre--painless sore	Blood tests--VDRL	Penicillin Ampicillin Tetracycline	Yes	Condoms	Heroin dependent individuals often have a false positive VDRL test. VDRL tests for antibodies to syphilis. If test is positive, other tests are performed to confirm diagnosis.

Sexually transmitted disease	Discharge	Symptoms	Tests	Treatment	Treat partners	Prevention	Special comments
Pubic lice	No	Itching in pubic hair area ("crabs")	Observation of "crabs" or eggs	Kwell	Yes		Wash all clothing and bedding and dry in commercial dryer to kill eggs. Wash combs and brushes in Kwell.
Venereal warts (condyloma acuminata)		Dry painless warts--flesh color on vulva, vaginia, cervix, and rectum	Observation	Small warts--burn with podophyllin. Large warts--cauterize, freeze, or use trichloroacetic acid.	If infected	Avoid contact until warts are cleared.	Do not use podophyllin on warts in vagina or cervix. Warts in vagina or on cervix should be cauterized or frozen. Treat early--they can spread.
Vaginitis							
Bacterial	Yellow-green	Itching, foul odor	Saline slide	Sulfa cream or vaginal suppositories	No	Good hygiene	
Monilia vaginitis (yeast infection)	Thick, cheesy, white discharge	Intense itching	Potassium hydroxide slide	Antifungal creams or suppository such as Gynelotrimin, Monistat, Mycostatin	Partner should wear condom until your infection is over.	Vinegar baths--½ cup white vinegar; cotton underwear; avoid panty hose, leotards. Decrease sugar in diet.	Yeast infections are very common. Women should learn how to maintain the proper pH in the vagina. Taking vinegar baths during and after periods often helps prevent these infections. The use of antibiotics frequently promotes yeast infections.

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8.

Vocational Rehabilitation/ Employment Development for Drug Dependent Women

Robert Inskeep, Ph.D.

THE NEED FOR VOCATIONAL SERVICES

This chapter was written as a guide for establishing or revitalizing rehabilitation services within substance abuse treatment programs that serve women. The need is great for woman-oriented vocational programing in substance abuse treatment facilities. Although women alcoholics are somewhat more likely than women in society at large to be employed (Schuckit and Morrissey 1976), women dependent on other drugs are unlikely to be employed or to have employment skills. Ryan and Moise (1979) reported that only 3 percent of the women in drug abuse treatment programs surveyed by the Women's Drug Research Project (WDR) were continuously employed in the 2 years prior to program admission. Thirty-seven percent of the women studied reported no employment at all during the same period.

Most women in drug abuse treatment desire employment (Gioia and Byrne 1974; Levy and Doyle 1974), apparently because only about one woman in five entering treatment is financially supported by others (File 1976; Moise et al. 1979). Many of these women must depend on public assistance or illegal sources of income. Drug treatment programs, however, have generally been unsuccessful in helping woman clients obtain employment skills or jobs. In the WDR sample, the rate of unemployment was about the same among women leaving treatment as it had been among women entering treatment (approximately 80 percent). Composite Client Oriented Acquisition Process (CODAP) data (Burt et al. 1979) reveal a similar picture; almost 80 percent of all women leaving treatment are unemployed. According to Richman (1966), a major factor leading to unemployment and consequent drug recidivism among chemically dependent women is the failure by treatment programs to recognize that the addict "after detoxification . . . continues to be the same vocationally limited individual . . . even though she may appear able to work."

To some extent this poor record has stemmed from the failure of administrators and staff within treatment programs to recognize the importance of employment as part of the overall rehabilitation effort (e.g., Edwards and Jackson 1975; Levy and Doyle 1974). The problem also stems from several other factors that make entrance into the work world difficult for drug-dependent women. Lack of education and prior job experience are problems for many of these women. Reed and Leibson (1979) found that less than half of the WDR sample had high school diplomas or GEDs when entering treatment. A large percentage of these women also reported no job-related identity. Of those women indicating a prior occupation, low-skill clerical and service occupations were most frequently named. In some cases, even basic survival skills (such as using a phone book, balancing a checkbook, or cooking a meal) were lacking. Colten (1979) found that woman drug abusers were less likely to use professional services than were other women. Many drug abusing women must turn to prostitution, other illegal sources of support (such as shoplifting), or welfare to help support themselves.

Most drug-dependent women have childcare responsibilities that must be considered in planning training or employment possibilities. Reed and Moise (1979) point out that even though they have significantly less income than male addicts, women clients are more frequently expected to provide primary care and support for their children. These women may also lack a knowledge of transportation systems and money for such things as transportation and lunches. Lodging and clothing are often inadequate. Medical, dental, and legal problems may interfere with obtaining or keeping employment. Andersen (1977) found that drug-dependent women suffered more physical illnesses during treatment than did drug-dependent men.

In addition to situational barriers, several other factors also make it more difficult for drug-dependent women to obtain employment. Employers often attach a greater stigma to women substance abusers than they do to men drug abusers (although the stigma attached to men substance abusers should not be underestimated). Colten (1979) found that a high percentage of addicted women felt that both men and women look down on female addicts more than they do on male addicts. The majority of women addicts surveyed stated that women addicts were "worse" than their male counterparts. One result of this attitude is an extreme degree of isolation (Tucker 1979). Chemically dependent women often have few associates or friends who are not abusing drugs and little idea of the kinds of behaviors that are expected of them on the job. Unrealistic expectations about working are fostered by lack of contact with the "straight" world and lack of experience. Low levels of self-esteem and assertiveness and high levels of depression have been found among women in a variety of drug and alcohol studies.

Paradoxically, although women often receive less job training in treatment programs, they are more likely than their male counterparts to look to the drug treatment program for assistance in receiving vocational rehabilitation and finding suitable employment. They feel less able to undertake these activities on their own and feel that apart from the program, they receive little in the way of support and assistance for their vocational aspirations.

Finally, women in our society generally face special problems in attempting to obtain satisfactory employment. These barriers include society's stereotypic perception of women as dependent and nurturant and primarily interested in passive service careers rather than in leadership and competition. Women clients are likely to come under pressure to find conventional "feminine" jobs.

This pressure may be particularly difficult for chemically dependent women to withstand, given the fact that compared with other women in society, drug-dependent women tend to hold more traditional concepts of a woman's "proper" role, even though conventional solutions are less likely to be satisfactory for them than they are for other women (Baldinger et al. 1972; Colten 1979; Miller et al. 1973; Wilsnack 1973). Similarly, researchers have found that some groups of alcoholic women value femininity to an unusual degree (Belfer et al. 1971; Wilsnack 1973). At the other extreme, subgroups of women alcoholics may openly reject feminine roles.

Traditional female jobs are often of a service nature (Bird 1970). Ninety percent of all caregiving positions such as nurse, babysitter, maid, and counterperson are held by women. Within a therapeutic community, DeLeon and Beschner (1976) found jobs assigned to women to be gender typed. Women typically engaged in washing, cleaning, and cooking, whereas men made repairs. Vocational programing in treatment facilities frequently reflects strong sex-role biases. The jobs available to clients will likely fall within traditional sex-role boundaries unless specific efforts are made to counteract this practice. Unattractive or financially unrewarding jobs may have been an addict's reason for rejecting the non-drug-abusing world in the first place. Efforts should be made to help women choose from the entire range of possible occupations so that they can find work that is sufficiently interesting and rewarding.

This chapter will outline several ways that programs can better meet the vocational needs of their woman clients. It stresses that adequate time and attention should be given to the planning stages so that the vocational component is realistic in terms of resources available and actual client needs. A variety of techniques will be suggested for dealing with problems and obstacles. The chapter points to the importance of identifying and utilizing resources available within the community. Support materials are listed in the appendixes.

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ESTABLISHING A REHABILITATION COMPONENT

Careful planning is the first step in initiating vocational rehabilitation services because of the complexity of services you will be called upon to perform. Areas to be considered include program objectives, staffing requirements, client needs, available resources, ground rules, and procedures.

OVERALL PROGRAM OBJECTIVES

The nature and scope of vocational rehabilitation services provided in different programs vary with many factors, including the scope of client needs, and the availability of program and community resources to meet these needs. The goals and objectives of your rehabilitation component will determine the scope of vocational activities pursued. You may choose to limit your objectives to "help clients gain exposure to the world of work" or "familiarize clients with their vocational interests and aptitudes" or "introduce clients to vocational resources in the community." In this case, you could operate with limited resources. Include treatment counselors' discussions of vocational issues in treatment groups. Designate one staff person as a liaison to State offices of vocational rehabilitation and employment services.

You may intend, however, to help clients "explore and map career plans," "enter and complete advanced training," and "locate and maintain satisfying full-time employment." In this case, more sophisticated resources will be needed, including at least one part- or full-time clinic staff person to specialize in vocational rehabilitation activities.

In addition to receiving educational services (such as GED preparation), basic skills training, and job placement services, clients can profit from advice on sizing up potential employers, filling out job applications, dressing for interviews, preparing concise resumes, handling difficult interview questions, and writing thank you letters to potential employers. These elements are usually included in job readiness sessions conducted by vocational schools, State rehabilitation and employment services, and colleges, but you may decide to offer such activities within your program.

Regardless of the extent of onsite vocational services provided, you must accept responsibility for addressing all vocationally related client needs. As Reed and Leibson (1979) point out, the needs of female substance abusers are many and varied. Any single need that goes unmet can undermine client success. Be prepared to address all possible contingencies either through onsite services or through a variety of referral linkages.

STAFFING

If multiple onsite services such as vocational testing, group occupational exploration, and job readiness services are to be offered, a full-time vocational coordinator will probably be necessary. Usually trained at the graduate level, vocational counselors are skilled at collecting and assimilating client data, helping develop comprehensive vocational rehabilitation plans, and procuring and coordinating the services needed to help a client secure and maintain satisfactory, gainful employment. Vocational counselors generally have expertise in interviewing clients to determine their vocational strengths and weaknesses. They are familiar with most physical and emotional disabilities and the ways these disabilities handicap entrance into employment. Their knowledge of assessment techniques, including a variety of commercial tests and inventories, is generally sound. They are skilled in helping clients translate skills and interests into plans for employment. Such plans and the steps needed to realize them draw upon the vocational counselor's knowledge of the job market, job requirements, and community resources available to help clients prepare for jobs. Program administrators might recruit vocational counselors from local or State rehabilitation, social service, or employment agencies or from school systems and graduate professional counseling programs.

In addition to meeting the specific requirements of your program, applicants should possess (1) a sensitivity for the concerns of women and the problems of gender role stereotyping, (2) an outgoing personality, and (3) the ability to coordinate many activities and services at one time. Consideration should be given to selecting a woman to fill this position. Bahna and Gordon (1978) observed that chemically dependent women found it much easier to discuss intimate details of personal problems with women staff members. Biener (1979) reported that a significantly greater number of woman polydrug abusers enter treatment when their first contact with the program was with a female rather than a male staff member. Mandel et al. (1979) reported many positive interpersonal and emotional gains for female addicts who participated in discussion groups led by women. If your program cannot hire a full-time vocational counselor, a vocational counselor from your State rehabilitation agency could serve as a valuable consultant. For example, the local rehabilitation office may be willing to provide your clinic with comprehensive assessment, planning, training, and placement services. Or they may choose to help your treatment program personnel provide some of these services themselves. The vocational counselor-consultant might recommend data that should be collected at intake that will be essential to later job preparation and placement efforts. The consultant could also train treatment counselors to assist clients in choosing appropriate vocational objectives. They can be helpful in instructing treatment personnel in techniques to be used in job readiness sessions and in providing up-to-date information on job market trends for client counseling.

In addition to the free services offered by State vocational rehabilitation agencies, many commercial companies offer training in ways to conduct job exploration and job readiness sessions. These 1- and 2-day sessions are offered for a standard fee, which may include the cost of the trainer's transportation to your facility. Your local State vocational rehabilitation agency should be able to direct you to these and other training resources.

MEASURING CLIENT NEEDS

In planning your vocational rehabilitation component, first obtain an accurate composite appraisal of the vocational needs of the clients in your program. In addition to asking women in treatment for suggestions, consider polling treatment staff members and community professionals who are actively involved in the problems of chemically dependent women. Anyone familiar with conducting semistructured interviews, such as treatment counselors, intake or social workers, or administrative staff, could conduct such a poll. Many rehabilitation agencies have used a structured, stepwise needs analysis procedure known as a Delphi Probe (Linstone and Turoff 1975), a procedure that, although lengthy, produces an accurate, usable picture of client needs. Other possible assessment techniques include the following:

- Written survey instruments. Checklists or openended questionnaires can be used to survey large numbers of clients and staff simultaneously. Questionnaires could be used to elicit clients' perceptions and their educational, training, and occupational needs as well as information about barriers to employment, such as lack of transportation, day care facilities, tuition aid, lunch money, tools, and adequate housing. Once compiled as a clinicwide portrait of client needs, specific educational, economic, social, and psychological data could become part of an individual client's record to help shape treatment and vocational rehabilitation planning.

- Client interviews. Consider interviewing clients regarding their vocational needs. This openended technique gives an interviewer the opportunity to probe areas of special concern to specific clients. These interviews could be conducted by treatment counselors, intake specialists, or social workers. For example, ask a client, "What do you need in order to get the job you want?" When a client responds with vague references to children, boyfriends, and debts, clarify her needs by asking further questions. This technique is particularly helpful for clients who have difficulty expressing themselves. When summarizing a needs assessment interview, remember to include your personal observations of client needs because clients often fail to perceive poor work attitudes or the absence of academic credentials as career barriers.

- Client group discussion. This technique may prove to be the best method for determining client needs. A women's group may be useful for discussing common interests and needs while providing needed support and understanding on common interests and concerns. Such ongoing groups can be conducted by skillful clinic social workers, treatment counselors, nurses, student aides, or recreational therapists. Begin by asking the members of a group to discuss the kinds of jobs they are interested in and the kinds of jobs they have enjoyed or disliked in the past. This type of spontaneous peer group discussion generally reveals information not obtained by more conventional means. Hopes and aspirations are revealed, the general level of risktaking increases, and more information is available for examination and discussion. This method gives both clients and staff a chance to support, as well as critique, various vocational strategies.

- Client data systems. Data systems already in place at your clinic (intake and State and Federal reporting forms) provide valuable demographic information that can be used to shape vocational programing. These records are sources of cumulative statistics on client academic attainment, income, skill levels, and family size. From these data you will be able to determine the percentage of women who may need childcare services, GED preparation, transportation, and basic work adjustment training. A systematic review of client records, including medical forms and treatment counselor observations, might indicate personality, medical, and behavior variables that will need attention if rehabilitation is to succeed.

- A note of caution. Remember WHOSE needs are being surveyed. As you begin to assemble your data into a final needs report, make certain that your conclusions truly reflect the needs of your clients, and not merely those of the staff. Levy and Doyle (1974) found discrepancies between staff and client perceptions of issues related to woman clients. Staff persons in their sample frequently failed to be aware of clients' suicidal feelings, concern about family relations, negative feelings about their bodies, feelings of inadequacy, and desire for employment. To avoid creating services that go unused, it is critical that the final assessment results truly reflect your client population. Therefore, it may be advisable to ask client representatives to critique your assessment conclusions. Even if no revisions result from this review process, the credibility of future rehabilitation efforts will be enhanced.

INVENTORY REHABILITATION RESOURCES

You should begin as early as possible to inventory the rehabilitation resources available in the community and to develop and maintain a system of contacts with these organizations. A knowledge of existing services will be important in planning the scope and activities of your component. Moreover, the knowledge of community resources that will emerge from such an inventory will be an important tool at every stage of operation. To capitalize on community contacts made during the inventory, the investigation should be conducted by the staff person who will later be responsible for vocational rehabilitation activities. A treatment counselor or staff social worker are good choices for this assignment. A detailed list of organizations that should be covered in this inventory appear later in this chapter.

Your Own Program. First, you should be aware of the resources available within your own program. Conduct an investigation of your program, collecting and analyzing data as you proceed. (You can use this as a way to critique your investigatory approach, so that it can be modified before you spend large amounts of time surveying resources available in the community.) Find out which special skills staff members possess and whether they would consider sharing these skills with clients. Reed and Moise (1979) suggest tapping the talents of staff persons to teach courses on nutrition and childcare. Others may be willing to instruct women in basic homemaking skills such as sewing, cooking, and managing money. Still others may be interested in demonstrating home or auto repairs. Ask staff members if they would be able to provide clothing for women about to enter the work world or serve as "personnel directors" during mock job interviews aimed at sharpening jobseeking skills. Check to see which contacts and resources in the community are available to staff members. Be certain you are aware of the programing that already exists in the clinic or agency at large (in-service training, social work services, transportation) that might meet some client needs. Also, determine whether existing programing could be adapted to meet other client needs. For example, GED teachers are often willing to drill clients on the kinds of math problems frequently encountered on job aptitude tests. Inventory the special skills that clients might be willing to share with others. Cowan and Inskeep (1978) found that rehabilitated chemically dependent clients were willing volunteers, anxious to help other clients in need. Musical instrument instruction, academic tutoring, and crafts demonstrations are a few services that program participants have provided.

Explore the feasibility of establishing specific vocational rehabilitation projects within the clinic. Talk with your administrators about the needs you have uncovered and the ideas you have for programing. Quite often they are aware of obscure sources of funding that are targeted for special needs of populations such as yours. Finally, question the feasibility of your clinic's serving as a source of paid work experience for some of your clients. Work exposure at treatment clinics can be an excellent source of supportive experience for clients and can result in savings for program administrators. Carefully weigh the pros and cons of such a policy for your clinic and identify enough staff members interested in supervising workers/clients before beginning the practice. Program administrators or department heads should be able to determine a need for extra receptionists, typists, maintenance workers, drivers, switchboard operators, and janitors. It is possible that local manpower agencies would be willing to fund a number of such transitional, entry-level positions at your treatment site.

Survey of Community Resources. A detailed list of organizations that should be contacted in an inventory of available resources is contained later in this chapter. Particular note might be taken of the following. Public schools often offer adult basic education, GED classes, co-op vocational programing, counseling, and information about community leaders and sources of funding for special educational projects. University graduate programs may be willing to provide teaching assistants or counselor interns to help bolster the staff at your clinic. Vocational rehabilitation agencies are most likely to offer consistent vocational rehabilitation support for your clients; these agencies can provide a variety of diagnostic, planning, restorative, training, and placement services to eligible persons. State employment departments are often involved in testing job aptitudes, providing career counseling, screening minority applicants for special training opportunities, and locating employment. Finally, you should gain a working knowledge of private sector resources that could aid in the design of an overall vocational rehabilitation component.

GROUND RULES

Before beginning vocational services, you should address a number of issues to prevent clients from manipulating staff members, to reduce conflict between treatment and rehabilitation staff members, and to limit miscommunication between staff members and outside employers.

- Decide at what point in treatment women will begin their vocational rehabilitation involvement. It should be soon enough to facilitate long-term objectives but late enough to allow clients ample time to detoxify fully from the effects of drugs. Three to 4 weeks is generally considered to be a sufficient detoxification period, after which vocational rehabilitation may begin.
- Discuss with treatment personnel the degree of vocational involvement clients will be permitted at various stages of treatment. Make certain that treatment needs are not sacrificed as vocational and educational involvement increases. The importance of quality, ongoing therapy increases as clients experience the stress of seeking training and employment.

- Consider limiting the type and location of employment your clients will be encouraged to seek. Ask yourself if jobs in bars and other establishments frequented by drug traffickers will be acceptable. Clients frequently see no danger in returning to negative environments for employment.

- Verify the effectiveness of treatment program mechanisms designed to keep treatment and vocational counselors from working at cross purposes. Vocational counselors in the community may be unaware of restrictions placed upon clients by the courts or treatment staff. A vocational counselor, working in isolation, might attempt a job placement that would interfere with a client's regular attendance at therapy groups or would expose her to a negative, self-defeating environment that could lead her back to chemical dependence. Clients are frequently frustrated in their rehabilitation efforts because treatment and vocational counselors place conflicting demands on them. To avoid these conflicts, special consultations should be arranged between treatment staff and vocational counselors from the community. Treatment staff should familiarize vocational counselors with the nature of chemical dependency. Between such staffings, the clinic's designated vocational rehabilitation liaison should keep community vocational counselors abreast of treatment developments by phone or personal contacts. Confidentiality regulations must be adhered to in sharing information about clients; be sure to have clients sign appropriate release forms.

- Determine the degree of latitude vocational coordinators will be allowed to keep abreast of community developments. Determine how much time will be granted for field work and attendance at seminars. Excessive controls may prevent the vocational coordinator from doing his or her job, leading to frustration and demoralization.

- Reach a clear understanding with treatment staff as to the importance of vocational rehabilitation activities for your clients. One of the most serious threats to successful implementation of a vocational service component is staff insistence that treatment activities take priority over all other substance abuse program activities. Vocational programing must be granted equal status in the mix of services offered.

STRUCTURING PLANS AND PROCEDURES

As noted, the success of your rehabilitation efforts will be maximized if you first secure a broad, accurate picture of (1) the needs of your clients, (2) the tools available to meet those needs, and (3) the rules and procedures you will use to conduct rehabilitation. With these decided, you can delineate the structure of your vocational service system. Six areas require special attention here; each will be described more fully in the next section.

- Client assessment. An assessment package will need to be designed to measure each client's strengths and weaknesses, including a structured vocational/social history form, psychological and medical records, test results, school records, and clinical impressions.

- Career exploration and preparation techniques. Secure the commercial counseling aids you plan to use during individual and group counseling and during vocational exploration and jobseeking skill sessions (see appendix A). Develop criteria for job readiness to enable you to differentiate among job-ready and non-job-ready clients. Commonly cited criteria include physical capacity, psychological readiness, knowledge and preparation for the target job, and readiness to engage in the jobfinding process.

- Rehabilitation service plan format. Devise a format for assembling all assessment and resource information into concise, individualized rehabilitation action plans. Vocational action plans generally resemble treatment action plans and cite problems and needs, long- and short-term goals, means for attaining these goals, and the timeframe required to obtain each objective. These one- to two-page documents describe specific client needs such as childcare, training, and job readiness deficiencies. They allow for periodic plan update and usually provide a place for both coordinator and client signatures (see appendix B).

- Job development and placement system. Begin to sketch the components of the system by which you intend to locate employment for your clients. Devise an abbreviated system for recording information about employer contacts and client interests and skills. Additional elements of a sound job development system are discussed later in this chapter.

- Client followup system. Establish procedures for keeping abreast of developments in the lives of your clients. Periodic phone calls, mail followups, contacts through friends and relatives, and encounters at social functions can help keep you informed.

- Vocational rehabilitation counseling and reference materials. Be sure that these are reviewed for their value in counseling chemically dependent women. See appendix A for a list of references in this area.

THE PROCESS OF VOCATIONAL REHABILITATION

Vocational rehabilitation services are most successful when conducted in an orderly fashion which includes: assessment of needs, creation of a service plan, initiation of planned services, placement in suitable employment, and provision of supportive followup contacts.

CLIENT ASSESSMENT

Your assessment approach will undoubtedly evolve as you gain experience, but elements common to most programs include a structured interview, testing results, and the observations of staff members. You might also want to include a sample job application blank. The thoroughness with which your clients complete it will indicate whether they need practice in filling out applications.

The Vocational Interview. The objective of the vocational interview is to appraise a client's strengths and weaknesses in areas critical to future employment. In conducting the interview, pay special attention to each of the following areas.

- Basic demographic information. Collect accurate information including client's name, current and future addresses, social security number, phone number, date of birth, marital status, number and age of children, and all current and future sources of support.

- Medical history. If incomplete medical records exist, question your client about her history of medical treatment, illness that has required hospitalization, and recurring illnesses. Make note of any drugs the client must take daily to insure good health. Discuss specific jobs that might be ruled out because of a medical disability.

- Work history. Collect information about all significant jobs your client has held. Be certain to record the names and addresses of past employers, dates of employment, positions held, supervisors' names, reasons for leaving, and the possibility of being rehired at each company. Determine which jobs she enjoyed and what features of jobs she enjoyed the most. Be sure to probe the details of any jobs she claims to have disliked.

- Educational history. In addition to noting the years of formal schooling your client completed, attempt to determine how well she can read and compute figures. Inquire about her ability to multiply decimals, add fractions, and read the newspaper. Participation in vocational school training should be noted and verified by requesting copies of skill certificates received at completion. Don't forget to inquire about training received during years spent in prison.

- Transportation. Determine whether your client has a reliable source of transportation at her disposal. Be sure to ask if she owns a car, has a valid driver's license, owes money for outstanding traffic violations or if she can easily reach a bus from her present or future residence.

- Criminal record. Ascertain the extent and nature of all past convictions. Be sure to determine if any pending charges might interfere with future vocational plans. Find out the limitations a client's probation or parole will place on her vocational plans.

- Significant others. Be certain to record the names, addresses, and phone numbers of several important associates of your client. Often the names of friends, relatives, doctors, lawyers, and probation officers will prove instrumental in keeping communication between you and your client alive. Determine which nonrelatives would be willing and suitable to provide references for jobs.

- Short- and long-range vocational interests. Probe your client for specific types of jobs she would consider holding for short or long periods of time. Determine the pay range your client considers acceptable. Ask her to fantasize about the type of job she would eventually like to secure. Make note of the setting in which she imagines herself working, including the interpersonal environment she would most like to encounter. Pay close attention to examples of work she would strongly dislike, and determine, if possible, the reasons for her aversions. Appendix C provides an example of self-examination exercises that can be used to help clients identify areas of interest.

- Interviewer impressions. Do not forget to include your impressions of the client in your interview report. Make note of her appearance, ability to make eye contact, cooperativeness, attitude toward work, motivation to work, and ability to set goals. Weaknesses in any of these areas are critical points to strengthen before job placement is attempted.

Tests and Records. You may choose to expand upon some issues raised during the vocational interview by selectively using some of the following resources. Care should be taken in selecting tests and inventories. Keep in mind that commercial tests are only one of many adjuncts to counseling. They provide only a partial picture of a client's strengths and weaknesses. Tests differ greatly in terms of their purpose and the population for whom they are intended. It is therefore best to speak with your program's clinical consultant before selecting any of these instruments. It will be the ultimate responsibility of the staff psychologist to order these tests and to monitor their use, so consult this person early. Unless your program has a full-time psychologist onsite who can administer, score, and interpret the results of tests, it is best to rely on self-administered, machine-scored, easily interpreted instruments. Several commercial interest tests are available that meet the above criteria, and they are easily used by treatment counselors engaged in vocational counseling with clients (see appendix A).

- Vocational interest inventories such as the Kuder Preference Record (Science Research Associates 1977), the Strong Campbell Interest Inventory (National Computer Systems 1971), or short interest checklists provided by State employment agencies are helpful.

- General aptitude tests such as the Differential Aptitude Test (The Psychological Corporation 1972) and the General Aptitude Test Battery (GATB), or tests of specific aptitudes for mechanical work, typing, or mathematics are valuable aids. GATB testing and subsequent interpretation of test results should be available free at local State job service offices.

- The Vocational Opinion Index (Associates for Research in Behavior 1975) is a self-administered inventory of perceived barriers to employment, which has been standardized on ex-substance abuser populations.

- The Minnesota Importance Questionnaire (Weiss et al. 1975) is a well-researched instrument aimed at identifying the mix of outcomes a person would like to experience in an ideal job. The University of Minnesota has prepared a number of helpful monographs to aid counselors who use this inventory.

- Medical specialty examinations designed to measure the severity of various physical and emotional illnesses can prove helpful. For example, an orthopedic examination might be needed to gage a client's mobility, physical strength, or capacity for spending long periods standing on a job.

- Treatment clinic records, including the results of any physical or psychological examinations, can help to substantiate characteristics that could help or hinder your client in holding a job. Such data might show that a client is brighter than she thinks, has a very short attention span, is poorly motivated, is quick to argue, or can work at several tasks concurrently.

- School records and transcripts often reveal interests, motivation, and academic attainment.

- Letters of recommendation from past employers can be informative.

Group Interaction. Complete your assessment of individual clients by noting their reaction to work-related questions posed to them in a peer group setting. In raising the questions, "Why work?" and "What problems do chemically dependent women have in getting work?" and "What important things do you want from a job?" you will be better able to gage a client's (1) motivation to work, (2) perception of the work world, (3) reasons for losing past jobs, and (4) overall level of hope or despair about the future.

Integrating Assessment Data. After assessment data have been collected, your task is to identify one or two viable vocational objectives for your client to pursue. A good starting point is the stated interests of your client. If she identified a specific occupation during your interview, designate it as a "provisional objective" until its feasibility and appropriateness can be determined. Should your client fail to identify any specific occupations of interest, statements regarding outcomes she expects from a job may help to narrow the field. For instance, a desire for freedom of movement, creativity, and recognition in her work might suggest advertising or sales occupations. The Minnesota Importance Questionnaire is noted for narrowing occupational objectives in this fashion. The Strong Campbell Interest Inventory and workshop evaluation results are also helpful in identifying provisional occupational objectives.

When a provisional objective has been identified, gage its feasibility and appropriateness by considering each of the following variables:

- Availability of employment. Do local and national job surveys indicate the availability of jobs in the target occupation? Generally such surveys cover a broad range of unskilled, semiskilled, technical, and professional openings.

- Availability of training. Do quality training programs exist to adequately prepare clients for entry into this field?

- Skill/aptitude level. Do test results and clinical observations indicate that your client has the necessary skills or aptitudes for this occupation?

- Motivation. Do the observations made by you and other staff persons indicate that your client has the necessary motivation to successfully pursue this objective?

- Personal attributes. Is your client's appearance, physical makeup, and general attitude sufficient to secure and hold a job in this field?

- Support. Are adequate emotional and financial supports available to insure occupational success?

- *Handicaps*. Do any other potential threats to job success exist?

- *Recommendations of others*. Does the pursuit of this occupation coincide with the recommendations of other professionals?

If no serious objections to the provisional objective arise from this examination, recommend it to your client for her consideration. When potential problem areas emerge as a result of this process, devote special attention to those weaknesses in the rehabilitation plan. Some problems can be overcome (e.g., appearance, support, availability of training). In cases where the likelihood of employment attainment in the provisional occupation appears low, be prepared to discuss possible areas of difficulty with your client and to explore alternatives.

ASSEMBLING THE REHABILITATION PLAN

The rehabilitation plan is a coordinating document that guides all efforts aimed at securing gainful employment for your client. Make sure it includes all the basic elements of a good vocational rehabilitation plan as you consider the many needs and interests of your client. Explain the need for various plan components, familiarize your client with the pros and cons of alternative courses of action, and encourage her to explore fully her careers of interest before choosing a vocational objective. For example, it might be possible for her to visit places of employment and talk with persons employed in that occupation. Finally, guard against premature plan disruption by carefully addressing the situational needs of your client and the psychological pitfalls commonly encountered by chemically dependent women.

Characteristics of a Good Plan. Successful rehabilitation plans generally incorporate the following features:

- *A clearly identified primary and alternative vocational objective*. The vocational objective is a compromise between the aspirations and the actual or potential abilities of the client and the realities of the job market. To insure the highest possible motivation, investigate all occupations that fall within the general job category of greatest interest to your client. To insure success, stress the selection of entry-level positions. Whatever the chosen job objective, make sure that your client has the skills or aptitude necessary to succeed in that field.

- *A clear description of the path to the goal*. The plan should clearly describe the ways the client will prepare for entry into employment. For example, the source of training services should be clearly identified. Responsibility for securing these services should be clearly designated. The plan should be written in language understandable to the client, and both the client and the coordinator should keep copies of the plan.

- A graduated plan for growth and change. The plan should allow the client to progress at a comfortable speed. A plan should not demand significant growth and development of your client immediately, but rather should allow for the gradual acquisition of skills and assumption of responsibilities.

- Clearly identified subgoals. The attainment of subgoals provides opportunities to reinforce and reward your client for progress made toward her ultimate vocational objective. It is difficult to complete a 1- or 2-year program unless there are rewards along the way. Completing each part of the GED, being admitted to college, securing a job interview, or moving into a new apartment may all be excellent opportunities to celebrate a client's progress.

- An opportunity for plan amendment and change. The best rehabilitation plan is a flexible one. Keep in mind that as your client matures, her needs and aspirations are likely to change. Be prepared to change the rehabilitation plan accordingly, adding and deleting various services and subgoals. Be alert to the need for increased therapeutic support for your client during stressful periods of her rehabilitation program.

Exploring Vocational Objectives. To help insure the success of a rehabilitation plan, you should encourage your client to become familiar with the occupation she intends to pursue. Consider the following techniques to increase your client's occupational knowledge:

- Commercial career guidance aids. Commercial guidance aids are an excellent source for clients to learn about specific job characteristics. Several guidance systems lend themselves to those who know little about jobs. The federally published Dictionary of Occupational Titles (Department of Labor 1965) provides capsule descriptions of thousands of jobs. When used with General Aptitude Test Battery scores, it provides information about aptitude levels associated with success in various occupations. It is organized to provide information about job families, which is helpful for identifying alternative job objectives.

- Career days and job exploration seminars. A more vivid way of exposing clients to information about occupations is through career days and job exploration seminars. Organizations such as the YWCA, chambers of commerce, and high schools generally sponsor day-long career programs, which include speeches and discussions by representatives from various occupational categories. Many college and universities sponsor career days specifically for women who are entering or reentering the job market.

- Job role model interviews. An excellent way for a client to learn about specific occupational objectives is to encourage her to conduct individual interviews with people working in the field of her choice. By interviewing workers engaged in a target occupation, clients may gain firsthand information regarding the best way to prepare for a given career. The interview approach gives a person time to decide whether a particular occupation will satisfy her needs. Since expectation of reward has been found to contribute significantly to human motivation (Inskeep 1978; Vroom 1964), such information can help insure occupational attainment.

  The steps of role model interviewing are simple. Once a target occupation has been selected, the client, her treatment counselor or vocational group leader, and her peers sketch out the questions she will ask during the interview. The vocational coordinator then helps the client locate a cooperative worker in the target vocation and arranges an appointment. During the interview, the client conducts herself as a researcher in search of answers, instead of as a job hunter in search of employment. The process is completed when the client returns to her vocational group or coordinator to report on her investigation. The results of this approach, whether they strengthen or alter the job objective, are generally quite dramatic. The client can also learn useful interviewing skills.

Situational Barriers in Planning. As your clients' vocational plans begin to take shape, be certain that services have been arranged to prevent the following issues from disrupting rehabilitation activities:

- Childcare. The need for childcare services among chemically dependent women engaged in rehabilitation programing is great; most heroin-addicted women face the daily responsibility of caring for children in their homes (Eldred and Washington 1975).

  Do not leave arrangements for childcare services to chance. If your treatment facility does not provide this service for mothers in training or employment, arrangements might be made with a relative or neighbor of your client. Reimbursement for these services can frequently be arranged through your State welfare or vocational rehabilitation service. Childcare services are often available through churches and schools (chapter 10 discusses some possible options). Consider offering such services within your treatment facility. Cuskey et al. (1978) noted decreased criminal activity, increased levels of self-esteem, and improved parent/child relations among heroin-addicted mothers whose treatment program offered live-in facilities for both mothers and children.

- Transportation and lunches. Wagner et al. (1977) found that the unavailability of transportation among women in treatment significantly limited client/counselor interaction. Do not assume that your clients will be able to meet transportation expenses independently. Most federally sponsored training programs provide allowances for these expenses. Your treatment program might consider establishing a petty cash fund to help meet costs not sufficiently covered by outside agencies.

  You may need to counsel your clients about using the allowance for transportation purposes only.

- Lodging and clothing. Clients may frequently cite unstable housing or shoddy clothing as primary reasons for dropping out of training or failing to get a particular job. You should make contact with welfare, family service and religious agencies as well as staff and other potential donors to help resolve such problems as soon as possible. Encourage the spouses and family members of your clients to participate in therapy to help alleviate problems at home.

- Medical, dental, and legal problems. As described in chapter 6, chemically dependent women experience significantly more physical illness than do male addicts. If your treatment program does not provide medical and dental services to clients, arrange to refer clients to these services in the community. Your State vocational rehabilitation agency can help in arranging medical and dental services for women preparing to start jobs. If you can provide these agencies with copies of any medical information in your possession, it will generally speed the provision of services. Community-sponsored medical clinics and university dental clinics are excellent sources of inexpensive treatment.

  Legal interruptions of rehabilitation plans can be reduced by identifying pending court cases, referring clients to free or reduced fee legal services, and providing lawyers with letters describing your client's vocational rehabilitation plans.

- Education. The need to improve basic skills, acquire the GED, and obtain survival skills should be addressed early. If vocational objectives require sharp academic skills and high school completion, you should enroll clients in remedial classes. Early classroom triumphs are excellent opportunities for increasing client self-esteem. Care should be taken to make classwork interesting and relevant to clients' job interests. Binion (1978) found that addicted women frequently cited boredom as a major reason for dropping out of school. Survival skills should be taught before clients begin training or employment. Practical tasks such as learning how to complete an application, use a phone book, write a letter of complaint, find a doctor, use the library, balance a checkbook, or cook a meal may mean the difference between plan success and failure. Such instruction might be given by treatment counselors as part of a regularly scheduled group session, or in special meetings conducted by staff social or recreational workers or student interns or volunteers assigned to your program.

IMPLEMENTING THE PLAN

Establish a Relationship Based on Trust and Mutual Respect. An absence of trust in the client/coordinator relationship can seriously handicap rehabilitation efforts. Your clients may approach rehabilitation services with a great deal of skepticism and doubt. You may question their readiness or motivation to change. Time should be allowed for both the coordinator and the client to develop trust. During plan development, each party should agree to carry out a few preliminary tasks, such as investigating resources, as a demonstration of good faith. Once both parties prove their sincerity, the job of solidifying a plan of action can proceed. Keep in mind that you can effectively show how to conduct an honest, game-free relationship by the way you deal with your clients.

Reduce Depression and Build Self-Esteem. Your clients will probably begin vocational rehabilitation activities with a low regard for both themselves and their ability to succeed. Colten (1979) observed that women who abused drugs scored lower on tests of self-esteem than did either men drug abusers or women who had not been drug abusers. Jainchill (1979) found drug-dependent women in therapeutic communities manifested lower self-esteem scores than did resident male addicts. Beckman (1978) reports similar self-esteem depression among women alcoholics entering treatment. From the outset, counseling strategies should be geared to reduce depression. To begin with, your ability to project a positive attitude and help clients gain a more optimistic outlook is crucial. Engage them in activities immediately. Involvement in occupational tasks, social functions, and moderate physical activity can all help to alleviate depression. Keep the lines of communication open between you and your clients by frequently offering support and by making yourself available for unscheduled meetings.

Vocational rehabilitation counseling should focus early on increasing self-esteem to foster confidence needed to negotiate the "outside world." Care should be taken to fashion a plan that strives to build self-worth through a variety of developmental tasks. Therefore, begin your rehabilitation efforts slowly, set mutual goals, pace assignments according to client energy levels and current skills, and praise successes as they occur. Be certain to offer only honest praise and use it sparingly. Persons with low self-esteem have been found to readily reject reinforcement they consider excessive or insincere (Bass and Baron 1967). In your contacts with clients, stress their present and past skills and emphasize the future value of these accomplishments.

Exploring training facilities or occupations is a good way to begin building confidence. Mastering basic reading and math skills as well as improving personal appearance can add to self-esteem. A client's completion of various phases of training or development of increased competencies at work and in daily life provides staff members with opportunities to reinforce growth and thus add to client self-confidence. Remember that clients often take inappropriate actions because of their low self-opinions. Inskeep (1978) found that low-self-esteem substance abusers chose potentially less satisfying occupations more frequently than did high-self-esteem substance abusers. Closely monitor occupational choices and other rehabilitation activities to head off attempts at self-sabotage.

Foster the Development of Work-Related Values, Social Skills, and Relationships. Improvement of interpersonal skills is a prerequisite to attaining and maintaining gainful employment. Glaring differences frequently exist between your clients' values and those of the subculture into which they are attempting to gain entry. They may not accept the importance the work world places on promptness, reliability, proper speech, or budgeting. Clients need to understand why the work world believes that these values are important and to know the consequences when employees do not demonstrate these values. In cases where value differences exist, the rehabilitation plan should include experiences that will reinforce the need for a change in values. Work adjustment training, interviews with working people, and reminders from the staff may all help to bring about change. Make certain that you reinforce your clients' progress toward responsible behavior. Praise them for abstaining from drug use and criminal activity, for improving relations with others, and for sharing feelings and using their reasoning abilities to make decisions. Encourage attendance at sheltered workshop work adjustment training sessions for clients who have difficulty dealing with authority figures, coworkers, or customers.

It is strongly recommended that peer self-help and support groups be available in your program to help addicted clients cope with the stress of changing their lives. Bahna and Gordon (1978) concluded that the most difficult adjustments facing the chemically dependent women they studied were coping with loneliness and a fear of dealing with the "outside world." Female self-help and support groups are a valuable adjunct to treatment and vocational rehabilitation. Reed and Moise (1979) pointed out that as women develop greater respect for other women in such groups, their respect for themselves will grow, along with a willingness to discuss topics previously kept to themselves. In freeflowing discussions, clients can pose questions, seek ideas, and ask for feedback on issues not adequately covered by treatment and rehabilitation resources previously mentioned.

Reinforce attendance in self-help groups such as Narcotics Anonymous and encourage attempts by your clients to engage relatives in family or conjoint therapy. Any progress made toward improving interpersonal skills will greatly facilitate successful assimilation into the world of work.

Encourage the Use of Community Resources. Encourage clients to overcome their reluctance to use community resources. Your clients may need social security cards, dental services, driver's licenses, or clothing allowances. Resources will have to be identified, appointments made, and transportation secured. Avoid the temptation to pick up the telephone and perform all these functions for your clients. Resist the urge to solve problems magically that have plagued them for years. Take extra time to remove the aura of mystery that surrounds many community resources by teaching your clients how to help themselves. This also can be an exercise in building self-confidence and self-esteem.

Be Aware of Difficulties Caused by Multiple-Role Demands. Female clients frequently cite children's needs as the reason for discontinuing training. Dickey (1979) reports that infants born to methadone-addicted mothers experience a higher frequency of health problems requiring rehospitalization than do infants born to nonaddicted mothers. Babysitters can get sick or move, leaving mothers without childcare services. Children with behavior problems may require the presence of their mothers in school or court. Social casework resources should be mobilized in advance to meet these emergencies as they occur.

Even when adequate childcare provisions have been made, mothers often choose to return to the role of full-time childcare. This can be a legitimate adult decision or one based on fear and guilt. When an issue like this arises among mothers in training, make counseling support readily available to help your clients sort out their conflicting feelings. Demands of a family or a spouse or lover can also cause a woman to feel she should quit work.

Reed and Moise (1979) suggested that chemically dependent women feel inadequate to meet multiple role demands. To stem these feelings of inadequacy, counsel your clients about options and alternatives available to them as they attempt to master the roles of mother, friend, student, worker, and client.

Confront Unrealistic Expectations; Insist on Adequate Preparation. Many chemically dependent persons are impatient to begin employment. They have long believed that the lack of money for such items as transportation, childcare services, and clothing was the primary barrier to securing employment. Once these needs are met, clients frequently fail to acknowledge the need to remove educational, emotional, and behavioral barriers to employment. You must insist that your clients receive proper work adjustment and skill training prior to attempting to secure employment. Your clients do not need the frustration of failure, which is likely to occur without proper preparation.

Reed and Moise (1979) suggested that self-defeating behaviors such as denial, manipulation, and misperception should be challenged firmly but not harshly by counselors. Confronting chemically dependent women may prove counterproductive to attempts at raising client self-esteem.

Respond quickly to comments about dropping out of vocational education programs by investigating the reasons for discontent. Such complaints might be manifestations of impatience to begin work or reactions to progress in the instructional facility. You may need to intervene on a client's behalf by scheduling three-way conferences among the client, yourself, and the instructor or program director of the agency in question.

Foster Self-Reliance. Reed and Moise (1979) pointed out that at least initially, drug dependent women often characterize themselves as needy and incapable. Because of the high levels of need found among many drug-dependent women, you will have to provide a great deal of support and guidance during the early stages of plan implementation. Take care, however, to move your clients away from heavy reliance upon you, your advice, and resources as soon as feasible. Early help in arranging interview contacts, securing transportation, and reminding your clients of appointments should give way to encouragement to rely on themselves. It is only through a gradual process of decreased dependency that self-confidence and self-esteem can grow.

Peele and Brodsky (1976) pointed out that persons who have been addicted to drugs may forsake a reliance on drugs only to acquire an equally intense addiction to various activities, people, or things. Thompson and Cole (1972) cautioned that all who work with addicts should avoid providing them with "environmental fixes" that foster a dependency on you and the goods and services you command. Despite protestations from your clients, you should expect increasing self-reliance from them as their rehabilitation plan unfolds.

Maintain Contact with Clients. As your clients enter full-time employment and prepare to terminate from treatment, make sure they understand that you will continue to be available to offer support and assistance. As a link between the program and the outside world, you are in an excellent position to help maintain your clients in the community. This can be done with a minimal amount of work on your part. Even if your former clients never call on you for help, it is important that they know you are there if they need you.

DIFFICULTIES POSED BY SOCIAL STEREOTYPES

Women in our society face special problems that tend to work against their successful completion of vocational rehabilitation programing. To succeed in helping your clients attain self-actualizing occupations, you must plan to support them against stereotypes. As your clients move toward independence and self-sufficiency, they will come under tremendous pressure to return to dependent relationships with men in particular. Irrational beliefs that they are inferior to men will be rekindled, and the compulsion to retreat from job training and employment will be great, especially given the stigma that chemically dependent women often feel. It is crucial to provide sufficient support to your clients at these times to help them gain the skills and confidence necessary to refute inferiority stereotypes.

You should also work with the women so that they recognize sexual harassment as they begin training programs and jobs. Some of the "irrational beliefs" mentioned above are regularly reinforced in some job settings. Sexual innuendos or direct pressure from co-workers or employers can undermine accomplishments. Should sexual harassment occur, women need to recognize it and take appropriate action. Various strategies for dealing with sexual harassment are described in Stopping Sexual Harassment, listed in appendix A.

Frequently, when a client's friends or relatives fail at refostering dependency, they may seek revenge by attempting to sabotage the client's rehabilitation plan. When promises of change or special favors fail to bring about the client's abandonment of the plan, the denial of cooperation, angry threats, and physical abuse may be directed at the client. When this occurs, increase the frequency of contacts with her and rally the support of her peers.

Your clients may be under pressure from friends, relatives, employers, and even clinic staff members to seek traditional female jobs. The jobs most easily obtained by your clients will probably be service-type jobs. Once a foothold has been gained in the employment market, and appropriate training and education have been obtained, there is no limit to the type of employment open to the recovered chemically dependent woman. Many rehabilitated women have found responsible employment in the business, artistic, manufacturing, and social service communities. To achieve lasting job satisfaction and self-actualization, clients should be free to choose their vocational objectives from the entire range of occupations, not the narrow band previously reserved for women. Therefore you should encourage clients to look beyond traditional female careers. Support the exploration of competitive, challenging positions by your clients. Encourage contacts with professional women who have broken away from stereotypic service occupations. Invite successful female professionals to address your clients during vocational group sessions. Introduce clients to literature that describes employment opportunities available to women.

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COMMUNITY LINKAGES

Preparing clients to enter the job market is only half of the work of the rehabilitation component. The other half consists of developing contacts and linkages within the community (or other components of the program itself) that can be used by your clients when needed. The overall effectiveness of the rehabilitation component will depend in large part on the number and strength of contacts with other organizations.

The specific kinds of linkages to be developed by your component depend on its goals and objectives. If vocational rehabilitation facilities within the program are limited, clients may have to receive most services elsewhere, including vocational counseling, rehabilitation services, training, and job placement. In this case, the work of the program would be to make the appropriate contacts and referrals and to monitor client progress within the context of the overall treatment plan. If your vocational component includes job development and placement, contacts with employers will be a major focus of community work.

Whatever kinds of community resources will be used, begin an inventory as early as possible and incorporate the findings of this inventory into the plan for the rehabilitation component. This plan should be based on a knowledge of the resources available in the community that can meet the varied needs of the women in your program. If you begin by approaching agencies and businesses searching for specific services to help particular clients, you will likely discover community cooperation lacking. If you approach employers and agencies in a friendly spirit of curiosity and learning, however, you will be surprised at the doors opened to you. Don't limit your inquiries to the issues with which you are concerned. In approaching community resources, allow them to take the lead. Listen to them explain who they are and what they do. During this process, they may reveal projects and resources that are generally kept private. In this way you can establish a system of valuable community contacts that can help your clients in a variety of ways.

TRAINING AND REHABILITATION SERVICES

Many types of community resources can help your program and should be contacted. The following paragraphs describe some of the more important sources. As you approach these resources, remain flexible. Also look for nontraditional services that agencies might perform.

Public schools are excellent resources for remedial education and related services. Begin by contacting administrative representatives in the departments of adult or continuing education of local public or community college school systems. Be prepared to conduct a frank discussion of the numbers of women in your program who need basic education and GED services. Ask about the feasibility of having an onsite instructor provided for your center. Administrators frequently are looking for outposts to provide basic adult education funded by Federal Adult Basic Education Grants or the new Displaced Homemaker Program. Be prepared, however, to open such an onsite class to non-substance-abusers if you cannot provide enough clients to qualify for subsidization.

Libraries contain information about community agencies, funding sources, and potential employment opportunities. They often stock directories of social agencies and local manufacturing companies, sample copies of civil service job tests, and programed texts for GED preparation. Libraries often sponsor or coordinate programs aimed at helping special populations such as young people, older adults, handicapped persons, foreign born persons, and single parents.

United Way agencies are chartered to provide a variety of social services, including medical and psychological care, childcare, transportation and shelter services, tuition assistance, and adoption assistance. It is especially helpful to talk with agency managers who are aware of program underutilization. They may be interested in establishing a cooperative referral agreement with your program. Make contact with a conscientious frontline counselor from each agency who knows how to navigate the maze of rules and requirements governing the agency.

Religious organizations such as the Salvation Army and Jewish, Lutheran, and Catholic social services are often good sources of food, clothing, lodging, counseling services, and work adjustment and skill training. These organizations sponsor programs that help former substance abusers. In smaller communities the Salvation Army often operates small, cottage-type industries that serve as a bridge to employment for many women.

Preapprenticeship training programs provide a source of entry into nontraditional jobs for some women. Operated by union locals, private corporations, or State employment services, these programs recruit and prepare minority candidates to meet skilled trade entrance requirements.

Private vocational schools vary in their ability to meet the needs of the former substance abuser. Take special care in evaluating private vocational resources. Be prepared to ask tough questions such as, "Who hires your graduates?" and "May I talk with some of your current students?" These and other relevant questions are covered in a free pamphlet entitled "The Pocket Guide to Choosing a Vocational School" (Federal Trade Commission Buyer's Guide #13, Washington, D.C. 1975). You will find that the better schools make remedial assistance available at the beginning of vocational coursework, and extra placement assistance is offered after coursework is completed. Tuition costs may range from a few hundred to more than a thousand dollars. If the school is one of more than 9,000 institutions participating in the U.S. Office of Education's Financial Aid Program, clients may qualify for a

Federal grant, loan, or work study assignment. Funding for vocational training for female drug abusers may also be secured from your local State vocational rehabilitation agency or CETA office. Contact the admissions officers of vocational schools in your area for additional tips on tuition assistance.

Sheltered workshops specialize in moving occupationally naive and behaviorally handicapped clients from unemployment to a work-ready status. Look beyond any initial impression that the workshop setting is inappropriate for your clients. Workshop evaluation and training can benefit chemically dependent women who (1) are unsure of their occupational interests and aptitudes and would like to sample a variety of jobs, (2) need to develop rudimentary interpersonal work skills, and (3) need to acquire basic occupational skills before entering advanced training elsewhere.

Few training settings provide such a supportive opportunity to develop interpersonal and technical job skills. Special emphasis in reading skills, hygiene, social activities, childcare, money management, and job placement is typical of the holistic approach used by most sheltered vocational workshops. A workshop evaluation can also be a good diagnostic tool for the vocational counselor because it is a practical way of assessing needs and narrowing job objectives. Workshop staff persons are skilled in translating their observations into practical suggestions for you and your client. Over the past decade, most vocational workshops have opened eligibility to chemically dependent clientele and arranged program financing through State vocational rehabilitation, welfare, or substance abuse coordinating agencies.

Colleges and universities have traditionally been a source of community-oriented programs. You may discover vocational testing, career guidance, medical services, scholarship aid, and remedial education classes available through local colleges. Contact the offices of adult education or the student services department of local colleges or universities for more information.

Vocational rehabilitation agencies provide a variety of diagnostic, planning, restorative, training, and placement services to eligible clients. Eligibility for services is based on the following:

- The presence of a documentable physical or emotional disability;
- Demonstration that this disability has handicapped the client in the employment market; and
- The likelihood that a client will become gainfully employed as a result of vocational rehabilitation services.

Your skill in documenting the presence of a substance abuse disability, its handicapping effect, and a positive prognosis for employment given proper support will play a major role in determining whether a client will be eligible for rehabilitation services.

Vocational rehabilitation administrators are frequently interested in establishing cooperative agreements with treatment facilities that can provide a steady flow of motivated handicapped persons. If you can provide medical and psychological documentation of client's substance abuse history and insure a constant number of program referrals, you can increase your chances of arranging timely rehabilitation services for your clients. Speak with caseworkers assigned to work with chemically dependent persons. Arrange to interview the agency's district office supervisor for tips on agency priorities and procedures for establishing formal cooperative working agreements. In the event that the district office supervisor you contact does not share your concern for chemically dependent women, contact the regional director of client services or the State coordinator for services to substance abusers and offenders. You may need to ask these persons to remind local administrators of the agency's mandate to service all disabled persons.

Social service/welfare agencies are the logical complement to State vocational rehabilitation services because they can provide for day-to-day living expenses incurred by clients as they train for new careers. The establishment of direct linkages with your local welfare agency is a necessity. Thousands of rehabilitation efforts fail when rent and utility bills go unpaid or seed money does not stretch beyond training to the time a job begins.

The identification and grooming of a conscientious caseworker and supervisor is a must for successfully negotiating with public welfare systems. You should quickly determine the feasibility of establishing formal support agreements with local welfare agencies. You should contact administrative assistants or the director of your county or State social service agency to propose ongoing support agreements. Be prepared to present detailed income and needs data for all women in your program, and be ready to argue the cost efficiency of transfer payments made to one entity--your treatment facility--rather than separate mailings to hundreds of different client residences. Stress the assignment of one or two caseworkers to coordinate all services to program participants. This will not only speed up provision of services to your clients but should also make the caseworker's job easier. To avoid miscommunication and duplication, one treatment staff person should be designated as a liaison to your local social welfare agency. He or she should be responsible for communicating the need for services to the appropriate caseworker. Ideally this function should fall to a staff social worker or community liaison agent. In their absence, any staff person with a good working knowledge of your agency's fiscal policy and procedures, as well as the needs of your clientele, should be able to fill this position.

The National Alliance of Businessmen is well organized to address the problem of how the unemployed can get jobs. Their knowledge of affirmative action outreach, apprenticeship openings, and business expansion plans is exceptionally detailed and current.

The National Urban League is an excellent source of information about educational, job training, and placement programs that have benefited minorities for years.

Supported work programs are growing in popularity as vehicles for providing on-the-job training for women and other minorities. They function as nonprofit corporations that receive their funds from a variety of Federal departments and private foundations. These programs generally recruit and train novice workers, assemble them into work crews, and secure contract work for these crews to perform on a paid, full-time basis. Preliminary studies by Mathematica Policy Research (1977) indicated that ex-addict participants in these stepping-stone programs earned more income, were less dependent on welfare, and engaged in less crime than did control group addicts who did not participate in supported work.

Women's organizations are often in the forefront in providing concrete services for unskilled and unemployed women. Local offices of the National Organization for Women would be aware, for example, of local efforts to achieve educational equity for women, funded under the 1974 Women's Educational Equity Act. Many displaced homemaker programs provide services your clients will need to enter the job market and may be persuaded to work with your clients. Such contacts can also help chemically dependent women understand that many of the employment-related issues they face result because they are women.

Employment programs for women are constantly searching for women who need special job training and job placement assistance. Several CETA-administered job programs actively solicit female heads of households for placement. For years the Work Incentive Program (WIN) has operated successfully in serving this target group. Now labor unions, the YWCA, United Way agencies, and a variety of State and Federal agencies are administering programs to meet the employment needs of this group.

JOB DEVELOPMENT AND JOB PLACEMENT

The identification and creation of job opportunities for your clients will place the greatest burden on your organizational and sales abilities. Whether engaged in the creation or development of jobs, or the placement of clients into available positions, you will be called upon to expend tremendous amounts of energy. To insure success you must use your own system for organizing the many names, companies, dates, and position requirements you will encounter.

- Keep track of all employer contacts, including the date of contact, name of the person spoken to, their needs at the time of the conversation, and their projected needs for the future.

- Organize your information about various target employers according to location, type of goods or services produced, types of positions typically available, and skills needed to qualify for these positions.

- Update your list of work-ready clients daily, making sure to include the types of jobs they are interested in and the skills they possess. For additional tips on refining your job development system consult Ferman (1969) and Bowman and Graves (1976).

Job Development. In the course of developing or creating job opportunities, you and your clients will face many frustrations. The most common impediments to locating job opportunities are economic recessions and employer biases against chemically dependent women. Goldenberg and Keatinge (1973), conducting interviews with 100 employers in the greater Boston area, found widespread discrimination against chemically dependent persons. The authors concluded that employers were reluctant to have anything to do with addicts, and in general were actively involved in trying to rid their companies of the chemically dependent. Less than 5 percent had developed policies favorable to the hiring of rehabilitated substance abusers, whereas over 65 percent used screening techniques to detect drug users among employees.

Over the past decade, employer motivation to discharge drug-addicted employees has changed markedly, as evidenced by the national proliferation of employee assistance programs. Unfortunately, biases against hiring recovered substance abusers still exist. In the face of such prejudice, several techniques can help you in your search for jobs for your clients. Consider adopting the following tips for successful job development:

- Prepare early for your encounter with an employer by reading company-produced brochures and publications and talking with other business people in your community about the target company.

- Know your clients' strengths and weaknesses and interests and dislikes, and be prepared to question how they might or might not fit into employment at the target company.

- Prepare a client skills bank so that you are ready with possible referrals to the occasional employer who will say, "I need five workers tomorrow, can you deliver them?"

- Develop and practice the presentation that you plan to make to each employer. Role-playing lends itself well to perfecting job development presentations.

- Seek out the decisionmakers in the company and interview them. The personnel manager may not always be the appropriate person to contact regarding the hiring of recovered substance abusers. Speak with supervisors and managers and listen carefully to their needs and concerns. Do your best to address their specific concerns.

- Be prepared to counter employer stereotypes about the chemically dependent as dishonest, unreliable, lazy, and dangerous people. Be prepared to discuss case histories of successfully rehabilitated clients. Offer to bring a few clients to meet the personnel director, or suggest a visit to your clinic to defuse their stereotypes. It may take skill and credibility to prove to an employer that your clients are truly recovered and ready to work. You may need to enlist counselors from public agencies to support you in these attempts to change opinions.

- Be prepared to offer consultation on drug abuse problems that the employer's company might be experiencing. Offer to introduce the employer to appropriate treatment and administrative staff members at your clinic for further consultation.

- Suggest the establishment of subsidized on-the-job training and job tryouts to employers with problems in keeping qualified, trained employees. An employer unable to bear the costs of 6 months of technical on-the-job training may welcome the chance to train your clients when training costs are offset by Government subsidy. Find out about agencies that frequently sponsor clients in on-the-job training. These include State employment and vocational rehabilitation agencies and placement programs sponsored by CETA and the Department of Labor.

- Provide close employer followup when an employer has no openings, expects to have a few openings in the future, or actually hires several of your clients. It is essential to maintain close contact. This not only keeps you abreast of new opportunities for placement, but gives employers the clear message that you intend to be available to help troubleshoot any problems that may develop. It also places you in an excellent position to support your clients during stressful periods of their adjustment.

Job Placement. Many resources are available to help you identify job openings for your clients. Described below are some of the more common sources of this information.

State employment services frequently provide referrals to many excellent training and employment openings. State and federally sponsored industrial surveys provide good information about occupations for which qualified workers are in short supply and geographic areas in which skilled workers are sorely needed.

State employment services work closely with well-established training programs such as WIN, the Job Corps, and a variety of apprenticeship centers. They frequently establish special referral agreements with businesses located within their district boundaries. Be sure to contact individual placement counselors, training specialists, and WIN coordinators. They are always looking for motivated candidates for training and placement opportunities. Point out that because of the nature of your long and personal association with your clients, you will be in an excellent position to screen referrals for them.

County agents and mail carriers are often the first to hear of job openings in suburban and rural areas.

The local chamber of commerce usually has current information about job openings and plans for company expansions in the community.

Treatment program board members are frequently associated with businesses and industries that can provide high-quality job placements. Consider giving these board members the opportunity to make a personal contribution to the treatment effort by helping to place some of your clients.

Manpower planning agencies are operated by many local, regional, and State governments. They serve as prime sponsors for a variety of paid training and work experience opportunities. Since the scope of these programs varies so much from State to State, you should seek out knowledgeable people in coordinating agencies and familiarize yourself with the peculiarities of programs funded under each locality. Use caution and investigate worksites selected for various manpower placements to make certain that the environment is both supportive and challenging enough to make work meaningful.

Civil service jobs are excellent for neophytes to gain work experience. Because of the high degree of bureaucratization and structure found in civil service agencies, they provide an excellent environment for a beginning employee. These jobs provide good opportunities to learn and put into practice new techniques for interacting with others and in general becoming socialized to the everyday work world. Quite often arrangements can be made with local and State civil service offices to mail job announcements directly to your program for posting. The best strategy to use in securing civil service jobs is to apply early. These positions tend to open up 6 months after they are announced.

Treatment facility employment may be available to a small number of rehabilitation clients in noncounseling positions. Before placing any clients in clinic employment, you should consider the pros and cons of such a practice. On the positive side, such jobs are more easily secured and open to support and intervention on your part. They generally prove to be a comfortable, familiar atmosphere in which clients can learn about work because most of the staff and clients are acquaintances. The work duties are generally entry level and seldom overwhelming for the new worker. On the negative side, familiarity with clients and staff may work to your clients' disadvantage. The opportunity for clients to enter into negative, self-defeating contacts with other program participants is always great. Staff frequently feel conflict over whether to treat a worker/client as an equal, rewarding and disciplining accordingly, or as a patient in need of special considerations and supports not afforded nonclient workers. The worker/client who is pulled off the job to attend group therapy or is oversupervised by a staff professional is often puzzled as to which role she should choose for her primary identity. An exploration of these issues with all staff should precede any decision to hire chemically dependent women to work at your program.

Former clients who maintain successful employment can often provide inside information about position openings, upgrading opportunities, expansion plans, and training programs. This is one benefit to be derived from maintaining a strong client followup system. They can also be excellent role models for women still in treatment.

CLIENT FOLLOWUP AND EVALUATION

CLIENT FOLLOWUP

Rehabilitation of the chemically dependent woman does not end with placement in a full-time, satisfying job. The typical recovering substance abuser requires months of active support and followup to insure success. You will need to be available to support your clients during the inevitable periods of self-doubt, peer sabotage, and conflict that occur after job placement. To insure early identification of a need for support, it is best to create a multifaceted system of followup. Under such a system, alternative ways to contact clients are available if the primary method of contact does not produce results. Consider including some or all of the following techniques in your system for maintaining client contact.

- Make arrangements with trainers and employers for you to contact your clients periodically at school or on the job. Encourage employers to contact you as soon as your clients begin to encounter serious problems.

- Collect the names, addresses, and phone numbers of several significant people in your clients' lives through whom you can maintain contact with your clients. Be sure to obtain written permission from your clients allowing you to talk with each friend, relative, social worker, probation officer, and doctor whose name they provide.

- Develop a standard feedback letter that can be mailed to your clients with a stamped, self-addressed envelope and returned by them at their convenience. This technique works particularly well for clients who work the same hours as you.

- Develop followup mechanisms that reward your clients for keeping in touch. For example, you might:

  1. Establish a clinic alumni association that regularly reunites for various social and cultural events.

  2. Conduct an annual followup survey in which clients receive $5 or $10 for answering questions during a 1-hour interview.

  3. Provide vocational guidance and job-upgrading services to employed clients who are looking for better jobs.

  4. Offer to provide rehabilitation services to the relatives of successful graduates of your program.

  5. Honor program graduates by asking them to be speakers or special guests at community functions related to drug abuse rehabilitation.

EVALUATION AND MODIFICATION OF THE COMPONENT

To insure the quality and effectiveness of the services provided by your vocational rehabilitation component, you should conduct a periodic evaluation of progress toward unit objectives. Remember that the goals and objectives selected for your component will dictate the criteria for measuring success. For example, if one program goal is the placement of women into full-time, permanent employment, then a tally of the number of job placements for a given year may serve as a satisfactory criterion of success. Some of the more common criteria selected for evaluating vocational rehabilitation services include GED or high school completions, changes in income, number of jobs developed, number of clients placed in employment, number of jobs retained more than 6 months, number of clients completing skill training, quality of jobs developed, and number of clients returning to drug or alcohol abuse and crime. Select your criteria carefully, make sure that all staff members are familiar with these criteria, and formalize procedures for the accurate collection of all data. By measuring your component's service record against objectives established for a given period, the need for program changes will become clear. Once specific weaknesses are uncovered, problemsolving solutions can be better focused. As new services are created and prior practices modified, new objectives will emerge to serve as benchmarks for rating the program in later months. In evaluating rehabilitation services, adopt a simple yet organized strategy. Consider including some or all of the following basic ideas in your evaluation process.

- Establish regular semiannual or annual dates for program evaluation.

- Measure progress toward specific program objectives that were established at the beginning of the period under scrutiny.

- Question staff persons, program administrators, clients, educators, and employers about their perceptions of your component's strengths and weaknesses.

- Solicit strategies for remedying problems from a broad base of client staff, outside professionals, clients, and employers.

- Modify your rehabilitation component by adding, altering, or deleting services and adjusting your program goals accordingly.

- Summarize the results of your investigation and plans for modification and send this information to all staff members.

APPENDIX A
SUPPLEMENTARY MATERIALS

MEASURING COMPOSITE CLIENT NEEDS

Needs Analysis. The Delphi Probe is a structured, stepwise needs analysis procedure used in many rehabilitation agencies. It uses a variety of measurement techniques to draw needs data from a cross-section of the rehabilitation community. Probe data are then refined through several presentations to assessment participants until the results represent an accurate, usable picture of client needs. For information contact the National Clearinghouse of Rehabilitation Materials, 115 Old USDA Building, Oklahoma State University, Stillwater, Okla. 74074.

Written Survey Instruments. Formats available in the literature include Gordon (1976) and Wolkstein and Richman (1975).

Client Interviews. For suggestions on conducting needs assessment interviews consult Gordon (1976). For ideas about areas to probe, consider conducting a thorough review of the literature on female addicts. Contact the National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Md. 20857, for a bibliography of pertinent studies, or secure a copy of Women and Drugs: A Bibliography from the National Coordinating Council on Drug Education, 1526 18th Street, N.W., Washington, D.C. 20036.

JOB READINESS CRITERIA

A representative list of job readiness criteria can be found in appendix H of Rehabilitation of the Drug Abuser (Kolber and Elias 1972).

EVALUATION OF REHABILITATION PROGRAMS

For information write to the National Clearinghouse of Rehabilitation Materials, 115 Old USDA Building, Oklahoma State University, Stillwater, Okla. 74074, or secure a copy of Program Evaluation: A Beginning Statement, the 10th Institute on Rehabilitation Services, 1972, from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

GUIDELINES FOR ESTABLISHING REHABILITATION COMPONENTS WITHIN SUBSTANCE ABUSE TREATMENT FACILITIES

These guidelines may be found in Gordon (1976) and the accreditation standards for substance abuse facilities published by the Joint Commission on the Accreditation of Hospitals (1979). Information is also available describing the overall rehabilitation process, including assessing needs, measuring strengths, identifying job objectives, initiating training, and facilitating job placement of female substance abusers. The Disability and Rehabilitation Handbook (Goldenson 1978) provides excellent insight into the techniques for working with a variety of disabilities, including substance abuse. For specific information on provision of services to the addict, you might investigate Vocational Rehabilitation in the Treatment Setting, a training package available from the National Drug Abuse Center's materials distribution center, Box 398, McLean, Va. 22101. For information pertaining to most aspects of vocational rehabilitation counseling, contact the National Rehabilitation Information Center, 308 Mullen, The Catholic University of America, Washington, D.C. 20064.

Tools available to aid in measuring client strengths and weaknesses include The Mental Measurements Yearbook (Buros 1978). This resource provides capsule descriptions of most tests in print and will help you determine the applicability of a given test for use with your population. To guide you in issues related to assessment interviewing, establishing and initiating rehabilitation plans, and upgrading vocational services, consider subscribing to The Journal of Rehabilitation Counseling, The Personnel and Guidance Journal, or the Journal of Vocational Behavior.

Job exploration sources include Employment Perspective: Working Women, published by the Bureau of Labor Statistics, Department of Labor, Washington, D.C. 20212. For clients interested in self-paced career planning activities, secure copies of career-planning and jobfinding texts such as How to Get a Job (Fregley 1974), Planning for Work (Catalyst 1973), and Your Job Campaign (Catalyst 1975), and Creative Careers for Women: A Handbook of Sources and Ideas for Part-Time Jobs (Scobey and McGrath 1968). Most of these aids are available in the self-help section of local college bookstores.

TOOLS TO AID IN CLIENT ASSESSMENT

Vocational Interest Inventories. The Kuder Preference Record can be purchased by qualified professionals from Science Research Associated, Inc., 155 North Wacker Drive, Chicago, Ill. 60606. The Strong Campbell Interest Inventory and its easily interpreted, computer-scored test reports are available from National Computer Systems, 4401 West 76th Street, Minneapolis, Minn. 55435. Short interest checklists can be provided by State employment agencies.

General Aptitude Tests. These include the Differential Aptitude Test (DAT) and the General Aptitude Test Battery (GATB), as well as tests of specific aptitudes for mechanical work, typing, or mathematics. The DAT can be purchased by qualified professionals from the Psychological Corporation, 757 Third Avenue, New York, N.Y. 10017. Distribution and use of the GATB is closely controlled by the U.S. Training and Employment Service.

The Vocational Opinion Index. Information on this index can be obtained from Associates for Research in Behavior, Inc., 3401 Market Street, Philadelphia, Pa. 19104.

The Minnesota Importance Questionnaire. For information about the MIQ, write to Vocational Psychology Research, Department of Psychology, University of Minnesota, Minneapolis, Minn. 55455.

COMMERCIAL CAREER GUIDANCE AIDS

The Directory of Occupational Titles and *The Occupational Outlook Handbook* can be purchased through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The Occupational Exploration Kit is produced by Science Research Associates, 155 North Wacker Drive, Chicago, Ill. 60606.

The Art of Developing a Career (Carkhuff and Friel 1974), *Who's Hiring Who?* (Lathrop 1976), *What Color is Your Parachute?* (Bolles 1977), and *28 Days to a Better Job* (Jackson 1977) can be found in the self-help section of most bookstores.

CHILDCARE

For information on childcare services, contact local social service agencies and the Displaced Homemakers Network, Inc., 2012 Massachusetts Ave., N.W., Washington, D.C. 20036.

Information on funding, licensing, and managing childcare services in treatment facilities is available from the National Clearinghouse for Drug Abuse Information, which offers NIDA Special Report Number 1, Series 43, *Child Care Provisions in Drug Abuse Treatment Programs*.

Parent training information can be found in "Parenting and Child Services for Chemically Dependent Women," chapter 11 of this volume; *The Growth and Development of Mothers* (McBride 1974); and *Communication and Parenting Skills* (D'Angelli and Weener 1976).

LEGAL ISSUES

Information about the kinds of limitations a criminal record can place on employment opportunities is available from the American Bar Association, Clearinghouse of Offender Employment Restrictions, 1800 M Street, N.W., Washington, D.C. 20036.

General advice on legal issues is available from the American Bar Association, Pretrial Intervention Service Center (same address as above).

CONFRONTING SEXUAL HARASSMENT

For information on this subject, you can obtain *Stopping Sexual Harassment: A Handbook* for $2.50 from the Labor Education and Research Project, Box 20001, Detroit, Mich. 48220.

SURVIVAL TRAINING

See "Survival Skills Training for Chemically Dependent Women" in volume 2 of this book and Grimstad and Rennie (1975), Gordon (1976), Leibowitz et al. (1973).

EXPANDING OPPORTUNITIES FOR EMPLOYMENT FOR WOMEN

Obtain copies of *Working Woman* magazine, available at newsstands and published by Hal Publishing Company, 600 Madison Avenue, New York, N.Y. 10022; and *Careers for Women in the 70's*, *Publications of the Women's Bureau*, and *Continuing Education Services and Programs for Women, Pamphlet 10*, all available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Materials that focus on nontraditional employment for women include *New Job Opportunities for Women* (Lederer 1975) and *A Woman's Guide to New Careers in Real Estate* (Rejnis 1977).

Career Planning. Write to the U.S. Department of Labor, Employment and Training Administration, Washington, D.C. 20213 for current copies of the newsletter *Occupations in Demand at Job Service Offices*.

COMMUNITY RESOURCES: TRAINING AND REHABILITATION

Preapprenticeship Training Programs. Contact your State employment agency; local union halls; libraries; the Bureau of Apprenticeship Training, Department of Labor, Washington, D.C. 20212; and the Human Resource Development Institute, AFL-CIO, 815 16th Street, N.W., Washington, D.C. 20006.

Private Vocational Schools. "The Pocket Guide to Choosing a Vocational School" is available free from the Consumer Information Center, Pueblo, Colo. 81009. Information on Federal financial aid is available in *Student Consumer's Guide: Six Federal Aid Programs, 1981-1982*, U.S. Government Printing Office, Washington, D.C. 20402. "Developing and Using a Vocational Training and Education Resource Manual," a 1977 Services Research Report from the National Institute on Drug Abuse, provides an excellent system for organizing and retrieving information about training resources in your community.

Federal Agencies. Contact the nearest Veterans Administration office for information about survivors' benefits and training opportunities. Secure a copy of *Federal Benefits for Veterans and* their Dependents from the U.S. Government Printing Office, Washington, D.C. 20402. Contact the Social Security Administration for information about dependents under the age of 21. Be sure to obtain a copy of the Government publication entitled A Woman's Guide to Social Security from your local social security office. Contact the Armed Forces for information about long-term training for part-time service in the Reserves. Contact the Department of Labor Women's Bureau, Room S3311, Second St. and Constitution Avenue, N.W., Washington, D.C. 20010 for clues to funds for special training programs. Finally, inquire about vocational programing for female substance abusers through the National Institute on Drug Abuse, Clearinghouse for Drug Abuse Information, 5600 Fishers Lane, Room 10A56, Rockville, Md. 20857.

National Alliance of Businessmen. For information write to the national office, 1730 K Street, N.W., Washington, D.C. 20006 or consult a phone directory for the office nearest you.

National Urban League. For information, write to the national office, 500 East 62nd Street, New York, N.Y. 10021.

Supported Work Programs. For further information about supported work programs, contact your local manpower coordinating agency or write to the Manpower Demonstration Research Corporation, 3 Park Avenue, New York, N.Y., or the National Clearinghouse for Drug Abuse Information, 5600 Fishers Lane, Rockville, Md. 20857. For further information about placement programs for women, contact the Association of Programs for Female Offenders, Women's Reformatory, PO Box 313, Rockville City, Iowa 50579; The John Howard Association, 537 South Dearborn Street, Chicago, Ill. 60605; and the 7th Step Foundation, 28 East 8th Street, Cincinnati, Ohio 45202.

Women's Organizations. For further information about techniques, issues, and materials common to groups of this type, contact the National Organization for Women, 425 13th Street, N.W., Washington, D.C. 20003, or the National Institute on Drug Abuse Program for Women's Concerns, 5600 Fishers Lane, Rockville, Md. 20857.

COMMUNITY RESOURCES: JOB DEVELOPMENT AND PLACEMENT

Job Development System. See Job Development for the Hard to Employ (Ferman 1969) and Placement Services and Techniques (Bowman and Graves 1976).

Employee Assistance Programs. For information about companies in your area that operate employee assistance programs, contact the Association of Labor and Management Administrators and Consultants on Alcoholism, 1800 North Kent Street, Arlington, Va. 22209.

Manpower Programing. For an overview of manpower programing nationally, contact the U.S. Department of Labor, Employment and

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Training Administration, Room 10406, 601 D Street, N.W., Washington, D.C. 20213.

Employment Services Offices. For a copy of the Directory of Local Employment Services Offices, write to the U.S. Department of Labor, Manpower Administration, 601 D Street, N.W., Washington, D.C. 20213.

If you decide to conduct your own job readiness seminars at your clinic, you can obtain excellent resource material on the subject from the Multi Resource Center, 1900 Chicago Avenue, Minneapolis, Minn. 55404 and from the Federal publication entitled A Vocational Component for the Drug Abuse and Correctional Agency (Gordon 1976). Consider supplementing these resources with books on job interviewing such as Sweaty Palms: The Neglected Art of Being Interviewed (Medley 1978) and How to Win a Job Interview (Robertson 1978). Secure copies of The Working Mother's Complete Handbook (Norris and Miller 1979) and McCall's Working Mother Magazine to help prepare your clients for the dual roles of parent and worker.

The Occupational Outlook Handbook is a compact source of written descriptions of the nature, training requirements, job outlook, and pay scales of hundreds of representative jobs. The Occupational Exploration Kit supplies excellent written descriptions for more than 400 occupations. The accompanying self-guidance program is an effective guide for helping clients select a vocational objective.

APPENDIX B
SAMPLE OCCUPATIONAL DEVELOPMENT PLAN

Client Name: Jane Client

PRESENTING PROBLEMS (potential barriers to employment):

UNEMPLOYED
EPILEPTIC (CONTROLLED)
NO WORK SKILLS
NO GED
CHILDREN TO CARE FOR
NO TRANSPORTATION
SKIN CONDITION
SEVERE DENTAL CARIES
COURT CASE PENDING
STILL USING DRUGS

SHORT-RANGE GOALS	MEANS FOR REACHING GOAL	TIME NEEDED
-Refer to GED class	Counselor will do 11/3	1 week
-Narrow down job aptitude and interest	Take SVIB and GATB (Strong Vocational Interest Blank and General Aptitude Test Battery)	1 week
-Refer to State Bureau of Rehabilitation	Counselor will collect paperwork	1-2 weeks
-Line up mom to babysit	Client will arrange	2 weeks
-Get dental work, dermatological, and epilepsy evaluation	State Bureau of Rehabilitation	2-12 weeks
-Refer to NSD transportation program	Counselor will provide information	1 week
-Refer to job developer to develop entry-level job leads	Laborer, clerk, janitor positions	2-4 weeks

LONG-RANGE GOALS		
-Secure job skills through training	Sponsored by Bureau of Rehabilitation	6 months-2 years
-Get and keep employment	Job developer and client	3-6 months
-Maintain drug-free state	Client	

LONG-RANGE GOALS--Continued

-Get GED	Client and board of education	10 weeks
-Get teeth restored	Bureau of Rehabilitation	12 weeks
-Get skin cleared up	Bureau of Rehabilitation	12 weeks

TREATMENT STATUS

Currently in treatment at H.L. outpatient clinic. Drops urine weekly. Counselor is John Scott, attends two evening groups weekly.

This plan has been developed by
and is satisfactory to both parties listed below.

CLIENT SIGNATURE

DATE

COUNSELOR SIGNATURE

DATE

APPENDIX C
SAMPLE SELF-EXAMINATION EXERCISES

Central to many occupational exploration and career-planning programs are exercises that help persons assess their positive attributes and learn how those attributes might find expression in activities and occupations of interest to them. Consider engaging your clients in some of the following tasks:

1. Consider asking your clients to describe themselves in 15 to 20 short "I am" statements that include a number of attributes and characteristics. Next ask them to indicate which of these characteristics they like and which they dislike. At this point, you might ask selected clients to share those attributes aloud and charge the group with the task of brainstorming jobs or careers in which those characteristics would be an asset. In the absence of a group session, individuals could be asked to investigate for themselves occupations in which these attributes could find expression and report the findings back to you. Once completed, your clients would be free to further explore occupations that caught their interest during the exercise.

2. As a variation of the above exercises, ask your clients to list all the fun things and pastimes they have engaged in since childhood. Next to these pastimes, have them describe all the skills, talents, or attributes they needed to accomplish them. Next, ask them to indicate which of these attributes they most enjoy putting to use, and have them speculate about the kinds of jobs that would require similar talents and skills to perform. As an assignment, have them verify the importance of these attributes by visiting the library or worksites to read about or talk to people engaged in specific occupations.

3. As a third variation of the above, ask your clients to list a number of things they have done in their lives of which they feel particularly proud. Your clients may need extra prompting on this, so be prepared to suggest areas to focus on such as a new skill they have learned, a hobby or craft they mastered, something done for another person, a shrewd purchase, completion of a laborious task, or a story or poem written. Next, determine which things your clients would derive pleasure, pride, or enjoyment out of doing again. From this point, you could use the techniques cited above to derive jobs in which these enjoyable, pride-producing elements might be experienced.

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Family Therapy Approaches and Drug Dependent Women

Bennet Wolper, M.S.W., and Zona Scheiner, Ph.D.

Recent studies have indicated that family therapy holds great promise as a treatment methodology for chemical dependency (National Institute on Drug Abuse 1980; Stanton 1979a,b). Reviewing these efforts, Basen (1980) concluded that more precise family therapy methods need to be developed for work with various subpopulations. The degree of stress, estrangement, and enmeshment reported in the families of chemically dependent women suggests that family therapy can be particularly useful; however, therapists working with these families will need to be sensitive to gender issues in implementing the therapy.

The task of this chapter is to (1) expand the perspective of chemical dependency in women to a family orientation, and (2) describe recent advances in family therapy. Although we cannot teach family therapy in one chapter, we can introduce basic concepts and types of family therapy, discuss how they can be useful with chemically dependent women, and suggest ways that therapists in drug abuse programs can develop family-oriented interventions.

We will first present evidence that suggests that a family therapy approach is useful with chemically dependent women and their families and introduce some basic concepts of family systems. Then we will describe three major schools of family therapy that have been used with chemically dependent families. Two other approaches are included because of their potential usefulness with chemically dependent women (although we consider them to be adaptations of the major schools and not pure "schools" of family therapy). By studying these models, therapists should be able to better evaluate research and clinical reports and select a suitable model based on their personal styles, client populations, and settings. The approaches are (1) multigenerational, (2) strategic, (3) structural, (4) ecological or network interventions, and (5) multiple family group therapy. Special issues related to the gender of the identified patient will be noted when relevant. Finally, we will discuss how to develop further training opportunities. The examples included in this chapter are not representative of the multiple problems and complex patterns typically found in families of chemically dependent women. They were selected to illustrate particular family concepts and therapeutic strategies without overwhelming the reader with too much detail.

Other reviews and descriptions of family therapy and chemical dependency are available that are organized somewhat differently (e.g., Beels and Ferber 1972; Gurman and Kniskern 1981; Kaufman and Kaufmann 1979a; National Institute on Drug Abuse 1980; Stanton and Todd 1979). The work of Wegscheider (1978) is also relevant for understanding family dynamics in chemical dependency, but it will not be described here because of space limitations.

DRUG DEPENDENCY, WOMEN, AND FAMILY TREATMENT

A major first step in developing a family orientation is to understand the role that drug-taking plays within a family and to find alternative ways to conceptualize or "diagnose" chemical dependency. Consider, for instance, the following fictitious example:

> Mary Landau, an attractive woman of about 40, is married to a loving husband who is a successful businessman. She is the mother of two beautiful children, an adolescent girl and a 12-year-old boy. Mary has a problem--she is dependent on drugs. It started slowly, when the children were younger and the days were terribly long. Wanting to appear relaxed and loving to her husband, she would take a tranquilizer before he came home from work. It helped; the minor irritations of the day didn't seem quite as important, and she was ready to listen eagerly to her husband's tale of his day, responding as both of them wanted her to. Soon, though, one tranquilizer wasn't enough, and taking it at five o'clock wasn't soon enough; the children became difficult earlier in the day, so she would take a pill to deal with them more calmly. When they went to school, things eased somewhat. But she would have another pill before they came home to be ready for them and their problems--it was difficult for her to watch them experience the hurts and pains of growing up. As time went on, though, she became dependent on drugs. Her children stopped bringing friends home from school, even though Mary promised them that she'd "behave." This problem stemmed from Mary's behavior at her son's birthday party. Her children said she looked terrible and embarrassed the family. She had taken tranquilizers to help her get through a party of 10 noisy 12-year-olds. She felt that nobody would help her, and she felt she was alone. Her husband became increasingly angry at her and threatened to leave if she didn't improve. As a result, he spent less time at home, and she needed tranquilizers to deal with her loneliness.

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Most therapists probably have heard this scenario played out many times, with different variations. The point of this chapter is not to discuss this problem nor describe it in more detail, but rather to look at Mary Landau's dilemma from a family or systems perspective, which may change how a therapist would treat her. For instance, some would diagnose Mary as a dependent personality--depressed, lonely, and unable to cope with a simple life. Her problems probably stem from difficulties with her own parents; perhaps she never felt loved or was rejected as a child. Others would assess her lack of meaningful roles and her environment and would focus on her husband, who is always working and thinking primarily about money and success.

How else could Mary handle her situation? She doesn't complain about John's absence or her loneliness. John can say he's seldom home because she's "high." They don't have to talk about what else is going on between them--their inadequate sex life, their loneliness, their feelings of betrayal. Instead, they can focus on Mary's problem with tranquilizers and alcohol. John must come home to take care of the children because Mary can't cope. This makes John feel like he's a good father. Mary's chemical dependency helps her husband show his children how much he cares.

Understanding family dynamics is not easy, but a family therapist would assert that drug use has come to serve a function in the life of the Landau family. Although they pay a terrible price for her drug use, they seem unable to mobilize to change it. Drug use helps them deal with conflict; it helps them avoid the dangers of being too close; it helps them avoid responsibility for negative feelings; and it changes the mood of the family when necessary. To change Mary's drug use would require addressing the purposes it has come to serve within the family.

This situation has probably developed gradually over time as a response to stresses of daily living. For women, like Mary, who reside in nuclear families, their ongoing daily interactions with other family members is the context which needs to be changed. Family therapists do not see "problems" developing separately from or simply as a response to people's ongoing lives. Alcohol and prescription drugs serve as both a response and a solution to particular types of relationships; the solution then becomes the perceived problem.

A family therapist who meets the Landau family would suspect that one difficult issue for them is conflict and the handling of disagreements. The drug she is taking--Valium--is a solution for the entire family; they do not have to cope with overt conflict concerning roles, work responsibilities, family involvement, and so on but can concentrate simply on Mary's "problem" with Valium.

Considerable evidence exists to support family-oriented interventions in dealing with chemical dependency. Stanton and Todd (1979), studying lower and working class black and white males, reported that 6 months after treatment family treatment groups

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differed significantly from those that did not receive family treatment in the use of illegal drugs, illegal opiates, and alcohol.

Although we know less about how family therapy approaches work when a woman is the chemically dependent member, findings about chemically dependent women suggest that family therapy is likely to be useful. Women entering drug treatment have been noted to be socially isolated--more isolated than male addicts, who are in turn more isolated than female nonaddicts (Tucker 1980; Wallace 1976). These women report having fewer friends, fewer romantic relationships, and greater feelings of loneliness than either of the two other groups. The relationships they do have seem to be more stressful and troublesome. When these women have partners, the partners are more likely to be involved in drugs also (Ryan and Moise 1979; Tucker 1980). In addition to feeling isolated, they are more likely than nonaddicted women from similar backgrounds to have children and to have them at an earlier age, and they are less likely to be living with the father of the children or any other sexual partner (Tucker 1980). The support they receive in caring for children seems to come more from family members other than spouses and from girl friends (Schwingl et al. 1977). About 30 percent of addicted women live with their families of origin or relatives, and many others live close to relatives (Moise 1979; Tucker 1980; Wallace 1976).

Some family approaches can be used to help women develop stronger and more helpful support networks. In addition, although these women are defined as isolated, many of them live in families of one form or another--either with their children or with their parents--and they may be involved with their extended families.

Drug problems for many women begin at about the time they should be leaving home, suggesting that leaving home is difficult for addicts and their families (Wellisch et al. 1970). Thus, the family is likely to be important in the treatment of a female addict--both the family in which she is living and the family in which she grew up. Binion (1980) noted that women who are involved with drugs often ran away many times in adolescence, and many quit school before graduation. Adolescence has traditionally been considered a time when young people begin to separate from their families and develop identities of their own (e.g., Erikson 1950; Muuss 1962). Younger addicts especially are involved with their parents and either reside with them or see them frequently (Ellinwood et al. 1966; Moise 1979; Stanton 1979a; Tucker 1980; Wallace 1976).

Many family therapists see this level of involvement as being more than coincidental; they look at it as part of the problem that is "solved" by chemical dependency. These young women can avoid the issues of separation and the pain of necessary family reorganization that growing up entails by fighting with their families about drug use. Family therapists consider drug use a "pseudo issue," not because it is unimportant but because it helps the drug user avoid more critical issues--e.g., fighting with parents about who they are and who they want to be. Such a "problem" enables family members to be both close and separate at the same time; the family remains involved because of the "problem," but at the same time they feel separate because everyone is frustrated and angry. Unfortunately, when clients are seen alone in therapy, they are often defined as the problem rather than as the problem-bearer for a family having difficulty with separation and differentiation.

It has been noted that from 20 to 50 percent of women who enter drug treatment were sexually abused as children (Pearlman 1980; Wasnick et al. 1980) a fact that is further evidence of the intensity of the parent-child relationship and the use of this relationship to avoid coping with marital problems. In addition to the loss of self-esteem experienced by these young women, other family problems generally exist in incest situations. Adolescence is also a time of emerging sexuality. When sexual boundaries are confused--as they are in adolescence--and broken--as they are in incestuous situations--to place the problem only within the personality of the young woman or other family members is to miss the critical interpersonal and family issues involved.

Beckman et al. (1980) noted another area of conflict in alcoholic women: They were rated higher on conscious femininity and somewhat lower on unconscious femininity than were nonalcoholic women. This finding supports other literature on addiction (e.g., Baldinger et al. 1972; Marsh 1978; Miller et al. 1973; Wilsnack 1973) that suggests that addicted women have more traditional concepts of appropriate feminine behavior. As a result, assertiveness, independence, competition, and taking active control of life would tend to create conflict for these women. Their attempts to conform to traditional expectations would most likely be approved by their families and physicians; methods (e.g., drugs) that would support these attempts would be encouraged until the methods themselves become problems.

Also, as noted throughout this book, addicted women are responded to more negatively by others than groups of drug dependent men or nonaddicted women (Beckman 1975; Colten 1980). Family therapists consider that self-esteem is a product of interpersonal transactions between people and within contexts, and is not an entity unto itself. Reed and Moise (1980) suggested that treatment issues should deal with positives and increase competencies; a way to achieve this end is to increase competencies within a context of reality--that is, the environment in which the individual must function. "I feel better about myself if I can be more competent with my children in front of my parents. If my being incompetent and feeling about myself helps me not separate from my mother (and my mother not separate from me), I need to feel competent and better about myself in her presence." We have to learn to use the context of the family so that we don't blame the family for "sabotaging" the treatment.

Chemically dependent women are more likely than chemically dependent men to be involved with a chemically dependent partner. To expect women, especially those with low self-esteem and high rates of depression and anxiety, to make changes that contradict the lifestyle of the man with whom they live is unrealistic and may guarantee failure. Although a few studies have suggested that male spouses may be less able than female spouses to shift their perspective to the family unit (National Institute on Drug Abuse 1980), if we can involve the men, we can change the environment in which both partners live. Even if a woman's partner is not chemically dependent, involving a mate and children in treatment allows expansion of the possibilities for increased life alternatives for everyone. Both spouses may learn how to handle conflict in more productive ways, and the "ghosts" from both their families of origin may be exorcized. A modified life environment also decreases the likelihood that the family will use chemicals as a means of dealing with the younger children's eventual separation from the family.

We thus suggest that to change the ways that a chemically dependent woman handles her life and her problems requires a change both in the family's way of relating and the addict's or alcholic's place in the family. The family is the context that needs to change in order for the addiction to change. Excluding parents, siblings, spouses, or children from the process of treatment will exacerbate rather than solve the addict's problem.

In the sections that follow, we will describe some of the major approaches to family therapy and ways they are implemented. Some attention will be given to the family patterns that may be transmitted across generations that a particular client and her family may be recreating. For example, many chemically dependent women report that one or both parents were or are alcoholic or have had psychiatric symptoms (e.g., Moise et al. 1981).

Family therapists do not necessarily address whether the generational transmission of alcohol or chemical abuse is hereditary or learned. They hypothesize that the behavior can be altered by changing the family's "automatic" responses to life situations. Some women will benefit from approaches that will help them and their families to separate so that adult roles may be assumed. Other women can be helped to develop more flexible and less destructive family patterns.

One caution is important before we begin. Although family therapy has the potential for addressing needs and issues that are important to chemically dependent women and their families, it cannot counteract the effects of a setting that is insensitive to the needs of women or compensate for a lack of gender sensitivity in a therapist. Hare-Mustin (1978) has described how family therapy approaches can reinforce stereotypes and incapacitating roles. The family therapist must be equally committed to each person in the family and guard against using different language and standards for evaluating male and female behaviors.

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Divisions of labor within the family, how and by whom decisions are made, and differences in expectations about masculine and feminine behaviors all need to be included in a family assessment. Therapists must also attend to the behaviors they role model during the therapy and the sometimes profound differences that exist in male and female communication styles. Some feminist and family therapists have urged that the therapist consider challenging the family's assumptions about gender roles as part of the intervention process (Babcock and Connor 1981; Corrigan 1980; Gurman and Klein 1980; Hare-Mustin 1978). Although we do not agree that a therapist should take responsibility for telling people how to live, we do feel that family therapists must carefully examine their own potential biases about gender, many of which will be subtle or even unconscious. Sometimes the therapist's attitudes, regarding gender roles, whether biased or not, are communicated to the family, even when the therapist is not intending to tell the family how to live. The therapist should also be prepared to help families examine the gender-related patterns and biases in their interactions.

OVERVIEW OF FAMILY SYSTEMS THINKING

THE FAMILY AS A SYSTEM

Therapeutic approaches described in this chapter consider the family to be the unit of treatment. They differ in the selection of the family members they work with and in the style and techniques of the therapist. All approaches assume that the family operates as a system of interrelated parts, a dynamic process organism, rather than as a static entity. The family is perceived to change as a result of the balance between internal and external forces. According to a systems perspective, interactions between family members form a continuous stream, and any particular behavior sequence is only a frame in an ongoing "movie." If we were operating the movie projector, we might see a mother slap a child across the face and take a Valium. To this we might say, "child abuse and chemical dependency." But moving the film backward, we may see that the child just kicked the mother, and before that the father screamed at her. Was the mother's hitting the child succeeded by the father's continued yelling and the child's kicking? Did the mother feel guilty and take a pill? The frame on which the therapist stops the camera influences what she thinks is going on in that system.

Systems thinking requires that therapists expand the lens through which they look at problems. A family therapist would examine the way the family is organized around the symptom (drug use) rather than focus only on the symptomatic member. Failure to take this approach can make the problem harder to solve. For example, Haley (1976) commented that in the process of labeling a child a delinquent or an adult an alcoholic or drug addict, one participates in creating a "problem" that makes change more difficult.

A therapist who describes a family problem by characterizing it in individual terms, e.g., an addicted woman with a character disorder, is creating a new problem instead of identifying the one that exists. The labeling process crystallizes and makes human dilemmas more chronic by creating statis entities rather than interactive processes.

A systems perspective asserts that family members interact with each other so that their mutual behaviors modify and control each other. When these behaviors are repeated over and over again, they become part of the family's system or interaction pattern. In one such cycle, the interplay between an abusing parent and an abused child includes the following dyadic patterns: (1) marital tension and threat of open marital conflict surfaces; (2) the father leaves or withdraws; (3) feeling abandoned, the mother drinks; (4) seeing parental withdrawal, child A soils pants or spills milk; (5) child B (well sibling) points accusatory finger at child A, bringing child A's transgression to the mother's attention; (6) drunken mother endorses child B as praiseworthy, turning her out-of-control wrath and frustration (due to anger at father) on child A; (7) child A protests and the mother abuses child A; (8) child C (rescuer), seeking to protect child A, calls in father; (9) father rides in as hero after the fact of the abuse, chastizes mother as another "child out of control," nurtures mother and children and makes peace, thereby equilibriating the situation until it is exacerbated again by mother-father conflicts (Vazquez et al. 1979).

This is a redundant cycle that is replayed often with more or fewer steps each time. It points out the basic systemic issue: Each member of the family participates in the child abuse in his or her own way. Conceptualizing the problem in this way allows many ways to change it.

FUNCTION OF DRUG DEPENDENCY

Family therapists with an interest in chemical dependency have applied systemic thinking in considering the function of chemical dependency in the family. With particular reference to alcoholism, Steinglass and colleagues (Steinglass 1976; Steinglass et al. 1971, 1977) noted that drinking can be thought to operate in families as a sign of stress and as a method of system maintenance. They assume that if a family could remain intact in the face of the severe disruptions caused by excessive drinking, by definition the family system must have become dependent on the drinking behavior. In their research, couples were conjointly hospitalized and provided free access to alcohol. The couples' behavior varied between two interactional states: one in which the alcoholic was intoxicated (called wet), and one in which the alcoholic was sober (called dry). The wet cycle, contrary to common sense, was less chaotic and less random, and therefore more predictable, than the dry cycle. That is, the researcher could more readily predict the behavior of both members of the couple when alcohol was involved. Steinglass and his colleagues hypothesized, therefore, that the drinking was a means for the family to solve some of their problems, which if unresolved could create a level of family instability and uncertainty that would threaten the continued security of the family.

Carter (1977), in her work with a family in which alcoholism spanned three generations, supports this concept. She hypothesized that because the alcohol seemed to serve some essential functions for the family as a whole, it would be impossible to simply stamp out drinking unless some modifications of the drunken behavior could be included in the family's interactions without anyone having to drink to "make" the needed behaviors happen. One function of alcohol in this family was to provide a "good time." All fun and recreation were associated with drinking, and whenever the mother was not drinking "she was grim, depressed and sullen." The husband, though generally affable and meek (when sober), became "belligerent and angry when drunk but later disclaimed total responsibility for his actions, blaming it instead on 'drinking!'" Carter concludes that "simply stamping out drinking in this framework would be also stamping out good times, affection, sex and anger" (p. 56).

In a similar vein, Wolper et al. (1981) contrasted tape recordings of an alcoholic family when wet (alcohol used) and when dry (no alcohol) and noted that the same family showed remarkably different styles of interaction in the two states. When the father was dry, the family appeared blank, affectionless, and isolated; but when the father was wet, all family members engaged in more intimate actions; they touched, laughed, and connected very much around father. In this family, the father had six unsuccessful attempts at detoxification and treatment; review of the tapes demonstrated why. Removal of alcohol would eliminate much of the life force and energy of the family. This loss had to be avoided, regardless of the cost and sacrifice made by individual family members. Wolper refers to the cyclic nature of these behaviors as the "dance of avoidance," because the family appears to be repetitively following a well-choreographed dance.

As a final example, Stanton (1977) noted that male heroin addicts often express loyalty obligations to their families through the use of heroin. Typically, as the addict begins to pull himself together and give up drugs, his parents begin to verbalize discontent with their marriage, which precipitates a relapse by the addict. The parents are then once again united in their concern, anger, and frustration at the addict. Stanton labeled this "pseudo-individuation" and noted that the loyalty of the addict is comparable to the role of family savior and religious martyr. "He [the addict] is suicidal in the sense that a martyr is suicidal. As 'Christ died for our sins,' he wears the mantle of both saviour and martyr, who it is hoped will take the family's worst with him when he leaves. If he dies then his death is a noble one" (Stanton 1977, p. 196). Also, if the addict dies, the function of his symptom remains permanent--the parents can stay together in mourning for their poor afflicted (and dead) son and never have to deal with the frightening issues of their own conflicts.

In brief, when family therapists look at chemical dependency they think of the chemical use as a symptom that serves a function in the family, particularly that of maintaining the family's status quo. They do not deny that chemical abuse is a particularly lethal symptom (for the individual) but stress its systemic function. This understanding enables them to work with the individual or family on replacing the symptom with more functional behaviors while respecting the needs that the chemicals serve. Thus, a family orientation would assist a chemically dependent woman to take responsibility for herself rather than be controlled by destructive family patterns. It also helps the family find more adaptive and less painful ways of addressing family issues. Although most of the above examples focus on men, the systemic functions are not likely to be much different for women.

As we scan the various theories, we will note their differences. There are, however, some common issues that all therapists agree are important; these include (1) family composition, (2) family life cycles, and (3) family functions.

FAMILY COMPOSITION

Who are the members of a family? Although the answer may seem obvious, it is actually subject to a range of definitions. The narrowest definition includes two married people and their children living together under the same roof. Other definitions include grandparents, uncles, aunts, and stepparents if they live in the same household. Other definitions state that people don't have to live together to be considered a family but do have to be related by blood or marriage. Still other definitions include unmarried individuals who cohabit (e.g., gay couples, unmarried heterosexual couples, single-parent families, close friends).

For our purposes, we will divide families into two categories--the nuclear family and the extended family. The nuclear family consists of persons sharing a household (with or without marital ties) and typically consists of two generations (parents and children) but possibly one or three generations (a completely adult household or one that includes grandparents). An extended family, however, is simply all relatives by blood or marriage.

Some family therapy approaches attend to the nuclear family, while others specialize in the extended family. It is important to keep this distinction in mind when reviewing the various approaches.

DEVELOPMENTAL LIFE CYCLE

Families, as do individuals, go through various predictable stages of growth, which we call the family life cycle. The first stage of family life is two adults living together, whereas the last stage could be the same two individuals living alone after their children have left home. Some theorists consider the first stage to be the unattached adult. It could also be said that the last stage is when one adult lives alone after the other has died. Other examples of life cycle stages include (1) the first child being born, (2) the first child starting school, (3) children in adolescence beginning to separate from the family, and (4) the last child leaving home.

As these examples suggest, each stage requires either a structural or membership change (as when a child is born), the accomplishment of various tasks (caring for the child), and a change in the rules that govern how members of the family are to relate to one another (spouses become parents). If, at a transition from one stage to another, the family rules do not change, then the possibility of problems occurring greatly increases. Some family therapists have gone so far as to say that "all the traditional diagnostic categories are seen as difficulties in the progression from one stage of the life cycle to another" (Madanes 1981, p. 20). Of particular concern here is the period when a child leaves home (see Haley 1980). Very often the drug addiction of a young female client and the alcohol or prescription drug dependency of an older female stems from the inability of the family to accomplish the transition from one stage to another. Table 1 describes the major family life stages, the tasks associated with each stage, and the change in rules required for the family to proceed developmentally.

Understanding the stage of a family's life cycle development can be an important tool in helping its members give up their need to have a chemically dependent member.

SPACE (PHYSICAL AND EMOTIONAL)

The relationships of family members to each other in space follows from an understanding of their developmental stage. As the family develops over time, different degrees of emotional and physical closeness are necessary and appropriate. The family can be compared to an accordion, expanding and contracting as the family song is being played. During the course of family development, members are closely related to one another in some periods and less so in others. For example, the family with a newborn baby may exhibit a pattern of relatedness characterized by touching, hugging, and sensitivity. But 18 years later this same family may not relate with the same degree of physical closeness when their child is leaving home; their emotional reactivity and sensitivity will be greatly reduced. As shown in stage 4 of table 1, the parents at this stage are turning their energies into career

TABLE 1.--The stages of the family life cycle

Family life cycle stage	Task	Rules
1. Between families: the unattached young adult	Accepting parent-offspring separation	Differentiation of self in relation to family origin Development of intimate peer relationships Establishment of self in work
2. The joining of families through marriage: the newly married couple	Commitment to new system	Formation of marital system Realignment of relationships with extended families and friends to include spouse
3. The family with young children	Accepting new members into the system	Adjusting marital system to make space for child(ren) Taking on parenting roles Realinement of relationships with extended family to include parenting and grandparenting roles
4. The family with adolescents	Increasing flexibility of family boundaries to include children's independence	Shifting of parent-child relationships to permit adolescent to move in and out of system Refocus on midlife marital and career issues Beginning shift toward concerns for older generation

TABLE 1.--The stages of the family life cycle--Continued

Family life cycle stage	Task	Rules
5. Launching children and moving on	Accepting a multitude of exits from and entries into the family system	Renegotiation of marital system as a dyad Development of adult-to-adult relationships between grown children and their parents Realignment of relationships to include in-laws and grandchildren Dealing with disabilities and death of parents (grandparents)
6. The family in later life	Accepting the shifting of generational roles	Maintaining own and/or couple functioning and interests in face of physiological decline, exploration of new familial and social role options Support for a more central role for middle generation Making room in the system for the wisdom and experience of the elderly, supporting the older generation without overfunctioning for them Dealing with loss of spouse, siblings, and other peers and preparation for own death. Life review and integration.

Source: Adapted from Carter and McGoldrick (1980).

and other personal issues while the child is turning his/her energies toward adult life.

In addition to contracting and expanding physical and emotional space over time, family members vary this space on a daily basis. Some families have breakfast together and then disperse for the rest of the day. Some members might come into contact with each other during the day, either directly or by phone, yet the family may not reassemble until dinner. At this point, their attentions and energy may become more fully focused. Sometimes the transitions of the day may be microcosms of large life cycle transitions. For example, a couple might get into a "trivial" argument when they first arrive home, an act that although unpleasant forces them to engage with one another. After the issue is resolved, they may feel more intimate. Thus, the argument serves as a reconnecting mechanism. The same phenomenon may occur in the morning, allowing for separation or making separation more difficult (as seen with school phobia). Just as a fight or school phobia can be considered a way of handling stress due to separation and reconnection, chemical dependency can also be a way that families handle these issues. Chemicals can be used in making daily transitions or larger life cycle transitions (as in leaving home).

Family styles of closeness and separateness also vary. Different families share space in different ways. Some families appear to be very close, both in shared activities and in degree of family intimacy; other families seem to require more distance. All families have to provide their members with opportunities for autonomy and independence as well as necessary nurturance and support. Each family does this differently, depending on its style of closeness and separateness. Families do not have to resolve these issues identically to be "healthy," but all families must resolve them.

FUNCTIONS OF THE FAMILY

As noted, the primary functions of the family are to provide its members with support and nurturance and to prepare them for eventual separation and autonomy. In addition, all families protect their members and are used by them as a base for negotiating with the outside world. To perform these various functions, the first task of the family is to stay together. Without the family's continued existence, its members cannot perform their required tasks.

Family therapists, therefore, look at the family's problems as solutions to the primary issue of staying together, both physically and symbolically. Family members will go to extreme lengths to maintain the family as it is and to keep the family from dissolving. Chemical dependency can be seen as one way in which family members solve this primary issue--staying together.

Although we know that substance abuse, for no other reason than its continued presence and resistance to change, serves important family functions, each family incorporates and integrates chemical abuse in its own creative ways. Chemical dependency can serve to maintain family unity, to regulate distance, and to avoid conflict. Various patterns are possible, and therapists must explore and understand the unique way each family uses chemicals.

HOW FAMILY THERAPY THEORIES DIFFER

Family therapists do not approach their work in the same way. They differ in their theories of the family and in their intervention strategies. These differences are due in part to the types of clientele they saw early in their careers and in part to their personal styles. Some therapists like to get actively involved with their clients; they argue with them, push them, and confront them. Other therapists, either for theoretical reasons or because they are uncomfortable with such closeness, allow their clients to proceed at their own pace.

Each approach, to some extent, also dictates what the therapist sees. Family therapists look at families in different ways, and so they do not always see the "same" family. There are pictures taken by travelers which show people as small specks against a large mountain. Other tourists choose to focus on the family and leave out most of the mountain. In family therapy, some therapists consider the nuclear family (mother, father, and children) as small specks and focus on the preceding generations, while others consider ancestors as background figures and concentrate on the nuclear family.

Both pictures are valid, depending on the intent. Therapists must select the view that will be most useful in their particular setting, with their particular clients, given their own personal styles.

Each therapist, however, must work with his or her beliefs and approaches. By becoming conversant and comfortable with one approach, a therapist will be able to obtain more information. Other approaches can eventually be incorporated as more experience is gained.

PERSONS THE THERAPIST SEES

The therapeutic approach chosen dictates which family members will be invited to participate in therapy. One extreme is exemplified by the Bowen (1978) approach, which primarily works with the one family member who is most interested and willing to work on changing his or her relationship with the family of origin. The therapeutic system consists of that one person (who may or may not be the identified patient) and the therapist. At the other extreme are the network intervenors, notably Speck and Attneave (1973), who encourage the family to bring to the therapy session as many of their friends, neighbors, extended family members, family doctors, lawyers, and so on as possible. There may be 50 to 75 people in a room with teams of three or four therapists. Obviously the two types of therapy sessions would look very different, even if the presenting problem was identical.

THERAPIST-CLIENT RELATIONSHIP

Some approaches (Minuchin 1974) encourage the therapist to act as a family "insider" and become a special and highly respected member. The Bowen (1978) approach strongly advocates that the therapist remain an "outsider" and not become too important to the family. When following the Bowen tradition, the therapist may function more as a "coach" than as a team member. The degree to which the therapist enjoys intimacy and can tolerate conflict and tension will help dictate the most compatible approach.

THERAPEUTIC FLEXIBILITY

When some family therapists talk about "being organized," or "becoming trapped in the family system," they mean they are acting in ways they do not want but seem to have lost their choice or flexibility in the matter. They have become "caught" in the family's characteristic patterns. When the use of chemicals masks other more frightening problems (e.g., potential family dissolution), the family will probably resist the therapist's challenge of their version of reality. The family may claim they want the use of chemicals to stop, but yet they will act in ways that perpetuate its use. The therapist's task is to maintain his or her ability to challenge the family and to resist getting stuck in the family's perception of reality. Each approach has to develop ways to protect the therapist from being "organized" by the family. Remaining an outsider is one way; using a cotherapist is another.

ASSESSMENT TOOLS

What information do therapists gather and what techniques do they use to gather it? A Bowenian therapist would question a patient about the prior use of chemicals in the individual's family of origin, about the closeness between the individual and his or her extended family, and about family history. The process of assessment is primarily that of dialog between the individual and the therapist, with the latter controlling the flow of information. A structuralist, however, would attempt to determine how the family is organized around the symptom by creating crises (known as enactments) in the ongoing therapeutic process. The therapist learns how things happen by observing the family in action and noting the degree of resistance to interventions aimed at change.

THERAPEUTIC GOALS

Therapies also vary in their stated goals, from those that concentrate primarily on removing the presenting problem to those that focus on changing the nature of the relationship between the individual and the extended family. The amount of time available and other issues will dictate a therapist's choice of treatment.

DURATION OF TREATMENT

Each approach handles length of treatment differently. Again, individual circumstances will affect the therapist's decision. The following sections provide more details about the five family approaches listed earlier. They highlight basic principles and techniques and suggesting application with chemically dependent women and their families.

MULTIGENERATIONAL MODELS

Multigenerational refers to several therapeutic approaches that explore the family over time--through three and possibly four generations. These approaches place greater emphasis on historical patterns within the family than do the other models we will explore. Within the multigenerational category are two major schools of family therapy: Bowen therapy and intensive family therapy.

Following our earlier analogy that each family therapy method uses different lenses and camera angles when working with families, the multigenerational approach tends to use a wide-angle lens and look down at the family from above. Problems that brought the family to therapy are seen as being larger than the family can comprehend and encompassing more factors than they can control. Therefore, the multigenerational therapist might encourage family members by saying that "continuing to blame each other will be fruitless, so we might as well work together to change the situation."

BOWEN THEORY

As noted earlier, Bowen theory is characterized by maximal distance and individuation of the therapist from the family. Bowen believes that families function as single organisms, with the identified patient being that part of the organism in which symptoms are expressed. Symptoms are part of a process that spans at least three or four generations, and families of origin on both sides contribute to the symptoms. Theories and techniques aid the therapist in understanding how the family process operates and provide tools to help family members change those processes. Although many of Bowen's techniques and theories are useful, therapists who deal with gender issues in family therapy have expressed concern that Bowen implicitly values intellectual (more masculine) processes more than emotional (more feminine) processes within the family (e.g., Gurman and Klein 1980; Hare-Mustin 1978). This implicit bias can have the effect of discounting women's styles and placing female family members (or nontraditional males) at a disadvantage during therapy sessions. Therapists should be aware of this potential bias and adapt Bowen's principles accordingly.

Assessment Principles. The genogram is one of the most widely used assessment tools in family therapy, and its development is credited to Bowen and his colleagues. The genogram is similar to a family tree, but the collected information is specific to the therapy process. The genogram is generally collected in a 2-hour interview, with questions alternately asked of each parent in a matter-of-fact style.

The style of interviewing is critical for two reasons: (1) to calm those who have entered therapy in crisis so that a reading on issues and processes is more readily obtained, and (2) to protect the therapist from becoming caught in the emotional upheaval that is characteristic of families in crisis. If this approach is followed, the therapist is not organized by the family, and the family experiences an alternative model for operating during periods of high intensity. The genogram is constructed by using symbols shown in figure 1.

The symbols are put together in the form of a family tree, showing the relationships and positions of each family member. Factual information, such as dates of marriages, deaths, divorces, and births are also recorded. Figure 2 is a sample genogram of the Landau family described earlier.

Critical areas of family life that are examined using the genogram include the following:

- Geographic location,
- Frequency and type of contact among family members,
- Emotional cutoffs,
- Toxic issues, and
- Triangles.

Responses to questions about geographic location illuminate how a family uses space to solve relationship issues. One classic example would be a daughter whose mother was overly involved with her during childhood; the daughter handles this intense relationship by moving 3,000 miles from home. She later enters marital therapy because she has difficulty staying emotionally connected with her husband. Alternatively, she may enter therapy with a problem similar to that of Mary Landau, the increasing use of alcohol or prescription drugs. The therapist in this tradition would recognize these actions as part of the pattern this family uses to avoid the emotional intensity of conflict and intimacy. We note that distancing from emotional intensity is a central

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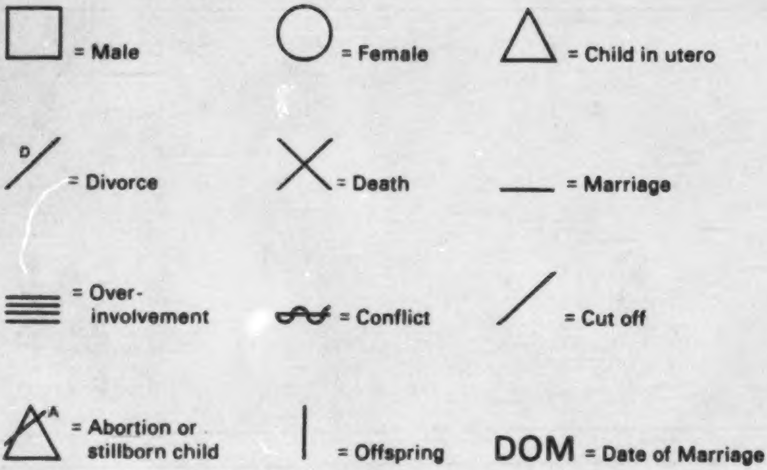
= Male
= Female
= Child in utero
D
= Divorce
= Death
= Marriage
= Over-involvement
= Conflict
= Cut off
A
= Abortion or stillborn child
= Offspring
DOM = Date of Marriage

FIGURE 1. Genogram symbols

theme in the family and that physical breaks and chemical dependency may be used to achieve that distance.

Frequency and types of contact among family members are also important to assess. Who in the family calls, visits, or writes one another and how frequently they do this is important to understand. For example, if one individual serves as the communication switchboard for the family, his or her death or incapacitation can result in a lack of connection between other members of the family, who do not know how to contact each other without the mediation of the "switchboard." The therapist also determines if contacts are spontaneous or ritualized, rigid or flexible.

As noted earlier, for persons who began having difficulties with chemicals during adolescence, separation is often an important issue in their families. Bowenian therapists would note the frequent combination of intense involvement of the chemically dependent individual with his or her family of origin and equally intense anger toward the family. The therapist then would pay more attention to how distance is regulated within the family.

Toxic issues, often universal ones such as money, sex, childrearing, and religion, are generally discovered when collecting other

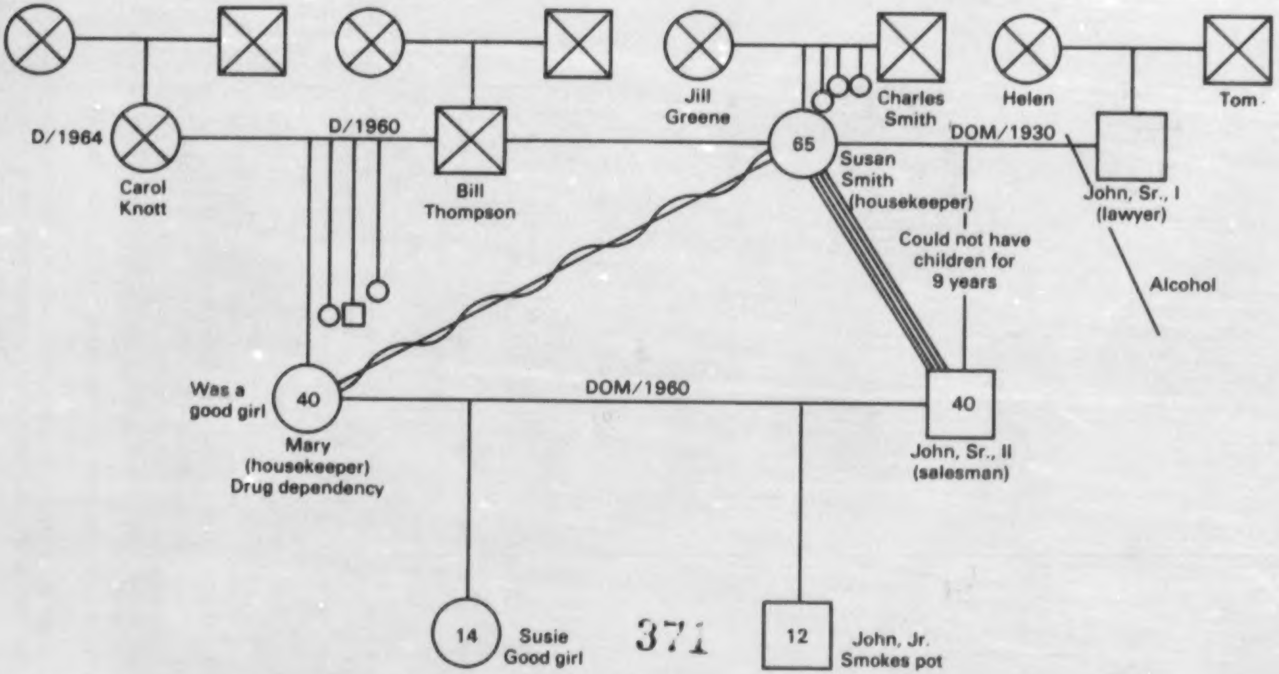
D/1964
Carol
Knott
D/1960
Bill
Thompson
Jill
Greene
Charles
Smith
Helen
Tom
65
Susan
Smith
(housekeeper)
DOM/1930
John, Sr., I
(lawyer)
Could not have
children for
9 years
Alcohol
Was a
good girl
40
Mary
(housekeeper)
Drug dependency
DOM/1960
40
John, Sr., II
(salesman)
14
Susie
Good girl
12
John, Jr.
Smokes pot

FIGURE 2. Sample genogram

information. During interviewing, the therapist pays careful attention to tracing the patterns of chemical dependency, caretaking functions, ability of members to leave home, violence between members of the family of origin, involvement with mental health institutions, and proscriptions for male-female behavior.

Chemical dependency within the family is an event or process of such central importance that much of family life becomes organized around it. The meaning that chemical substances acquire is different for each family, and although the therapist has general guidelines, he or she must determine what drug use means in that family. The therapist must also look for behaviors that are linked to or complementary with the drug or alcohol dependency. Identifying these patterns can help illuminate the way chemical dependency functions in the particular family system.

For example, the Landau family demonstrates several complementary characteristics. Sexuality was a taboo subject, but sex role proscriptions were powerful. Women were regarded as either caretakers (nurturers) or as fallen women, whereas men were seen as either respectable, God-fearing "real" men or as irresponsible boys. Although the men "drank a lot," only the irresponsible boys were labeled as alcoholics. The women provided caretaking functions and gave nurturance to all the males, but especially to the "boys" who could not manage to leave home; these "boys" functioned as professional failures and were the recipients of much attention and concern. Women who deviated from their roles as caretakers generally resorted to the use of substances; thus, they became "fallen women."

This contrast between caretaker and wayward women is evident in the results of research about both alcoholic and heroin-addicted women (Colten 1980; Wilsnack 1973). In their struggle to behave in rigidly proscribed roles, women who could not fit into the stereotyped "feminine ideal" seem to have chosen another rigid role ("bad, chemically dependent woman") to break out of the first.

Bowen stresses the importance of the triangle as the basic building block of the emotional system. He asserts that when emotional intensity between any two individuals gets too great for either one or for both, they will summon a third party to diffuse the anxiety. In families, this third party is not necessarily human and may be the use of chemicals (Fogarty 1979).

Family triangles can be seen in all parts of the family system and should be tracked as they change over time. As families move from one developmental stage to another, new attachments are made and old ones are modified. Families often have difficulty in handling this process, and problematic triangles occur. For example, as a young adult prepares to leave home, either to marry or begin an independent life, her primary attachment begins to shift from her parents to her outside world (with or without a spouse). The parents ideally turn to each other, to work, or to some other activity to fill the gap left as the child leaves home. If, however, the parents' relationship had been mediated by the child, the gap between them can become a void that they try to fill by "holding onto their child." One way of handling this problem is for the young person to become involved with chemicals, thus enabling the parents to maintain their involvement in her life and to prevent her from actually beginning a life of her own. As mentioned earlier, this type of problem serves the function of separation without separation because the child and the family believe that they have changed relationships when in fact they are still intensely involved.

If the young person gets married, one or both of the parents may attempt to intervene in her relationship with her spouse, thereby transforming the mother-father-child triangle into a parent-child-spouse triangle (see figure 3a).

Triangles take a variety of forms. One family may attack or denigrate a prospective spouse in order to avoid the shifting in relationships, while the family of the other spouse may invite the new couple to become active members of their system, thereby creating other triangular relationships (see figure 3b). The triangulating process can get quite complicated. The new couple is caught in a series of interlocking triangles. As they move in one direction, toward the husband's family, stress becomes transmitted to other parts of the system, which may lead to behaviors by either set of parents aimed at reestablishing previous, more stable situations. They could then become involved in battling each other over their respective families. Alternatively, the spouses can unite with one set of parents against the other set, thereby creating a new triangle (see figure 3c). A potential danger of this solution is the possible cutoff of one spouse, for instance the wife, from her parents. This cutoff makes it more difficult for conflict to be expressed in the new marriage. As the wife's dependence on her husband and his parents becomes greater, her ability to individuate herself is reduced. As conflict goes underground, potential marital problems may erupt, one of which might be the eventual use of chemicals (particularly if chemical abuse is an issue in any of the families of origin). Another potential difficulty might arise later when the children of the marriage attempt to leave home, recreating the earlier struggles and cutoffs.

Therapeutic Goals and Techniques. The primary goal of Bowen therapy is for the patient/client to become "differentiated" both within the nuclear family and particularly within the family of origin. To do this, the patient must be able to change the part played in the emotional triangles of the family and to maintain that change regardless of the family's response. A primary goal is to maintain emotional contact with each member of the family without using third parties, either humans or objects, as go-betweens. The task of therapy is to aid the patient in a three-step process:

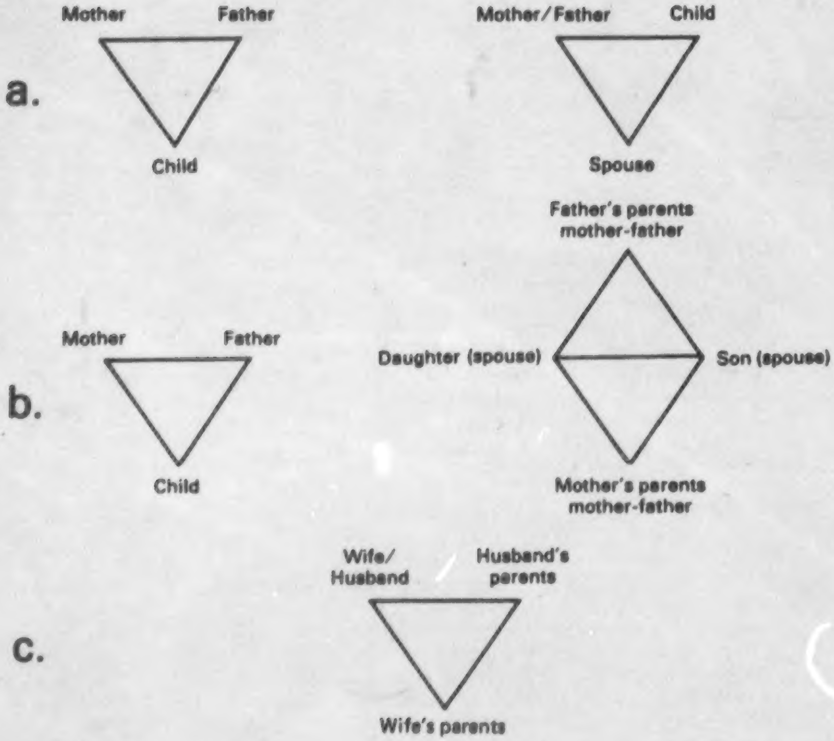
a.
Mother
Father
Child
Mother/Father
Child
Spouse
b.
Mother
Father
Child
Father's parents
mother-father
Daughter (spouse)
Son (spouse)
Mother's parents
mother-father
c.
Wife/
Husband
Husband's
parents
Wife's parents

FIGURE 3. Triangles

1. Change the response to family members,
2. Anticipate the family's reaction to change, and
3. Plan the response to those reactions.

Some techniques for accomplishing the process of differentiation are as follows:

- Open up emotional cutoffs. One response to difficult relationships within a family is an emotional or spatial cutoff between various members. These cutoffs often mask issues that cannot be discussed. Once cutoffs are established, the issues they conceal may become less potent. For example, when a therapist asked a recovering drug addict about her uncle (her father's brother) she replied, "I haven't seen him for 15 years." In this case, the uncle was a recovering alcoholic. By ending the cutoff and establishing a relationship with the uncle, she risked the anger and rejection of her father because of a falling out he had had with his brother. Yet when this relationship was established, the toxic issue of chemical dependency became exposed and less powerful, since it no longer masked the pain in the brothers' relationship.

- Use reversals. A technique that often works in shifting family patterns is coaching clients to do the opposite of what they normally do in response to other family members. For example, with a daughter engaged in a power struggle with her father over "who is right," encouraging the daughter to ask her father for help in a problematic area may loosen rigid responses. This technique must be done with positive intent and not to trick, take revenge, or be sarcastic; otherwise, it may backfire and create further entrenchment.

- Relabel through humor. Humor can break through the overly serious quality that characterizes families stuck in repetitive conflict or despair. Relabeling the interaction in a humorous fashion may help family members gain a new perspective on their interaction. For example, a woman complained bitterly to her therapist about her husband's conversational style at a party. The therapist turned to the wife and said, "I really don't think you should take him anywhere with you until he learns how to behave right" (Carter and McGoldrick 1976, p. 20). Putting her complaint in this perspective allowed her to see the quality of her complaint without encouraging her defensiveness through criticism. Family members can learn to do this with each other.

Protection of the Therapist. Bowen believes that therapists must examine their own families of origin and differentiate themselves from the multiple triangles in which they are caught to protect themselves from being organized by the family. The primary training tool is coaching trainees in that process. Therapists are outsiders whose usefulness depends on not getting involved in a family system--either their own or their patients'.

INTENSIVE FAMILY THERAPY

In Intensive Family Therapy, the therapist works directly with the extended family members in the same room. They attempt to work with the nuclear family and both sets of parents. The therapist "takes the problems back to where they began, thereby making available a direct root to etiological factors" (Boszormenyi-Nagy and Framo 1965, p. 206). It is asserted that by including adult siblings, parents, and grandparents, feelings of being "left out" of the nuclear family or being "blamed" for their problems will be reduced.

Another methodological difference is the use of cotherapy teams to prevent the therapist's becoming organized by the family. Male-female cotherapy teams are preferred, with the classic masculine-feminine "personality" traits demonstrated (e.g., firm and tough versus supportive and accepting). Hare-Mustin (1978) said that Boszormenyi-Nagy explicitly supports sex-stereotyped roles, but these differences need not be and should not be divided between therapists along traditional gender lines. Therapists must guard against the danger of this occurrence to avoid the issue of gender stereotyping among chemically dependent women. One purpose of therapy is to enlarge a family's conceptions of both the feminine and masculine roles; without careful attention, this type of cotherapy might, in fact, support a more narrow conceptualization.

Generational loyalty is another important concept for the family therapists. Boszormenyi-Nagy and Framo (1965) and Framo (1981) argued that much of the problematic "glue" in family relationships occurs because of unexpressed loyalty issues that exist among family members. For them, every move toward emotional maturation represents an implicit threat of disloyalty to the system. The therapeutic task is to release the loyalty ties so that relationships can be freed.

An example of generational loyalty can be seen in the family of the heroin addict. Stanton (1977) noted that male heroin addicts often express and attempt to meet loyalty obligations to their families through their use of heroin. If the family is not involved in treatment, as the addict begins to get himself together, the parents begin to express discontent with their marriage; then the addict generally relapses, thereby uniting the parents once again in their concern, anger, and frustration at him.

STRATEGIC COMMUNICATION APPROACH

All family therapy uses strategies, but the approach known as "strategic" is more intentionally planned and more direct than other strategies. Family therapy, for this group, is a challenge that requires specific strategies and game plans.

Strategic communication therapists are much more interested in how a system works than in what the content of the system is. They attempt to understand the rules in a family system as an alien would attempt to understand the rules governing human behavior without knowledge of our languages and cultures. They assert that attempting to understand what occurs within any given individual--for example, motivations, thoughts, and fantasies--will hamper rather than support the therapist in his or her efforts to understand and change the client system. In other words, focusing on individual issues could slow the process of change (Haley 1976, 1980; Madanes 1981).

ORIENTING PRINCIPLES

Strategic therapists have developed several axioms of communication that define how people communicate and how they define their relationships. The therapist tracks these communications to detect significant family rules.

All Behavior Is Communication. One cannot not communicate because even the refusal to send or receive a message is a communication: "I don't want to talk to you," communicates as loudly as the content message "I'm angry at you."

Messages Have Report and Command Functions. This is a complicated way of saying that any simple statement can have two purposes: for example, "it's raining" can be pure information or a command to take an umbrella. The voice inflection, context of the situation, and the nature of the relationship provide the information necessary to understand the meaning of a given message.

Command Messages Define Relationships. For instance, a hierarchical relationship in which the mother has more power is demonstrated when a mother orders and a child obeys.

In Families, Command Messages Are Patterned as Rules. As a mother consistently orders her child to obey and the child consistently obeys, a rule (or performance expectation) develops that governs how mother and daughter relate to each other. A different but equally "legitimate" rule would evolve if the child consistently disobeyed and the mother consistently did not reinforce her order.

Rules Must Change as Families Move Through Different Developmental Stages. The rule of daughter obeying mother, if it continues to be rigidly adhered to during adolescence, is a potentially nonfunctional situation because a developing adolescent should be increasingly independent of the parents.

The Inability to Change Relationship Rules Is at the Root of System Dysfunction. As noted above, an adolescent and her mother need to change the rules governing their relationship. Eventually, the daughter has to take responsibility for her own behavior. If a family system resists that change, problems can develop. One possibility would be the appearance of a symptom in the daughter that would change the rules while appearing not to change them.

The use of drugs is a perfect example of how this ambiguity can be manifested. The adolescent has full control (in opposition to her mother) over her intake of drugs (autonomy) and at some point she loses that choice to the drug itself (dependency). The pseudo-independence (reliance on drugs) causes her, in the eyes of the family, to be seen as incompetent and in need of protection. "Surely," her parents say, "any person who is so hopelessly 'hooked' on drugs as she is cannot expect to be treated with the trust and respect of a mature individual. Therefore," they continue, "we must control her" (for her own good, of course). As they try to get her to stop taking drugs, however, it soon becomes apparent that they cannot succeed because they cannot control their daughter (her autonomy). What is interesting about the choice of drugs as a symptom is that it allows both parties to continue their struggles for control, while letting them deny that they are struggling because of the addictive quality of the drug. "Everyone knows it is the drug that is the root of the problem, not our relationship."

In addition to the above axioms, three key ideas are part of the strategic communication therapeutic system: (1) a property of systems known as homeostasis and feedback, (2) the analysis of the family in terms of sequences of behavior, and (3) the function the symptom has in the family system.

HOMEOSTASIS AND FEEDBACK

The early observers of family systems were both impressed and confused by the ability of the family to "keep things the way they are" regardless of how hard the therapist attempted to change them. For example, a recovering alcoholic might be given a birthday party where alcohol was served or be offered a favorite brand of alcohol as a gift.

Rather than blame the individuals in the family, the strategic communication therapists were convinced that the system itself operated according to certain principles and therefore determined how people in the family would act. From General Systems Theory (Von Bertalanffy 1968) they borrowed the concepts of homeostasis and feedback to explain this phenomenon, and by so doing they were able to free themselves from blaming the family for "bad motivation and malevolent deeds."

Homeostatis describes a system's ability to maintain its equilibrium and adapt and react to its environment. A system will resist change that exceeds its ability to adapt or that would disturb its equilibrium. If a family has operated for a long time with a chemically dependent member, family members will generally act in ways that maintain the dependency even against their own apparent self-interest. The chemically dependent member is important to the stability of the system as a whole. The mechanisms that maintain this system are known as feedback. Behavior is one part of the system and serves as feedback to the system to change its activity in another area. Positive feedback is behavior that increases activity in the system, and negative feedback refers to behavior that decreases activity. In our example of the birthday party, the alcoholic's abstinence threatens to change the family and its rules. The presence of alcohol is a negative feedback message that the system is attempting to return to its previous equilibrium by decreasing the nondrinking behavior.

BEHAVIOR SEQUENCES

Behavior in families does not occur in random fashion but in predictable patterns or by repeated sequences of behavior (Haley 1976). An example of a typical sequence of behavior in families would be the following:

Step 1: Father uninvolved. The father is not involved in the family and spends a lot of time out of the home.

Step 2: Adolescent smokes pot. The youngster begins to get out of control and her grades decline.

Step 3: Mother incompetent. The mother ineffectually tries to deal with the child and the father becomes involved.

Step 4: Father competent. The father deals with the child effectively.

Step 5: The adolescent's grades improve and she begins to reduce her pot smoking.

Step 6: The mother becomes more capable and deals with the child and father in a more competent way, expecting more of them.

Step 1 (repeat): The father leaves again. The father once again becomes uninvolved in daily family activities.

As this example shows, the behaviors taken together form a cycle. This cycle occurs over and over again in different contexts and insures family predictability and homeostasis.

THE ROLE OF THE SYMPTOM

Within this model of therapy the symptom plays an important role. The family system is thought to be self-regulative (homeostatic), and therefore the symptom is seen as a mechanism for self-regulation. If the symptom is removed, the family's means of maintaining control is eliminated. As an example, parents often detour their conflict through a child who has developed symptoms--in this case, drug abuse. The problem for the family is that if the symptom is alleviated and the adolescent turns straight, then the parents' unresolved issues become exposed, creating stress in the marriage. When this happens, many clients seem to fall apart and return to the use of chemicals. This regression is therefore seen by the strategic communication therapist as a way to maintain family balance. Because of the symptom's central role in the family, it becomes a central focus for the family therapist as well (Haley 1980; Papp 1980; Weakland 1976).

Earlier we discussed the family of Mary Landau. Mary Landau's drug addiction also serves a function in maintaining the family's system. Her drug taking makes possible the avoidance of open conflict about issues other than her use of Valium. She and her husband, John, do not have to deal with his absences, her resentments, and so on; instead, they can focus on the Valium problem and avoid the possibility of change in their relationship or their family.

ASSESSMENT PRINCIPLES

The therapist who works within the strategic communication approach sees a different family than does a therapist who uses the multigenerational approach. The strategic therapist looks for patterns. S/he tracks data that demonstrate how people relate to each other rather than asks family members to report on how they relate to each other. These therapists assert that memory tends to be inaccurate and unreliable and that the reporting is also colored by attempts by the patient to impress or influence the therapist. The strategic therapist relies more on unearthing the cycles discussed earlier (e.g., husband absent, mother takes drugs) either through careful questioning or observation than in asking people what they think happened. The questions of the strategic therapist are that of a journalist--who, what, where, when, and how. When Joan takes drugs, what does father do? What happens then? What does mother do?

As a way of framing the therapy, the strategic therapist must address two initial questions: (1) What is the symptom and what is the cycle or pattern that contains it? and (2) What would happen to each member of this family if the symptom were no longer present? The therapist's initial task is to identify the cycle that serves as the negative feedback loop for the system and maintains the drug-using behaviors. Interventions are designed to develop a picture of what the family members do and say in response to the symptom, which itself must be carefully identified and defined. An example of clearly identified problems would be a "child who does not look for a job," "a child who will not eat," "a child who smokes marijuana in the house," or a "mother who uses drugs and doesn't take care of the kids consistently."

After the problem has been clearly defined, further questions are pursued. When does it occur? Where does it occur? How often does it occur? How do other people feel about the problem? How do people become involved with the problem?

The therapist also observes how the family acts in the office as a way of identifying the cycle. The next series of questions has to do with the family's attempted solutions to the problem, assuming that if these solutions were successful the problem would cease to exist. Therefore, the strategic communication therapist is careful to identify solutions that have failed, both to avoid repeating the same unsuccessful solution and to help identify the sequence of family behavior that maintains the problem. In the three-person cycle of father, mother, and adolescent, each person's response could be seen as an attempted solution to the situation that directly preceded it, e.g., the mother's incompetence encourages the father to become involved. The strategic communication therapist assumes that these solutions, although ineffective in eliminating the problem, become reified and institutionalized as ways for the family to maintain its stability. This stability is so important that the family continues with a symptomatic member and often presents a paradox to the therapist. Families request that the therapist eliminate the symptom from the system but leave the system intact.

THERAPEUTIC TECHNIQUES

Strategic therapists believe that action causes change. Rather than discuss a problem, the therapist seeks to use the symptom as a way of introducing change. Thus, the strategic therapist focuses on the problem. Haley has stated that "the first obligation of a therapist is to change the presenting problem. . . . If that is not accomplished, then therapy is a failure" (Haley 1976, p. 129).

The techniques that follow are based on the notion that the family will resist the therapist's attempt to change them. The therapist does not view this action as malicious or sabotaging but as a natural consequence of the family's reliance on the symptom to provide stability.

According to Papp (1980), the paradoxical intervention "is one that if followed will accomplish the opposite of what it seemingly intended to accomplish." It depends on the family's not following the therapist's instructions. The instructions, therefore, must be repulsive enough to the family so that the family resists following them. Their resistance then serves to accomplish the therapeutic goal. The fascination of this intervention technique is that the tasks are no more than exaggerations, sometimes bordering on the absurd, of the family's ongoing behavior. For example, if a therapist identifies a mother as overly close to her daughter, the therapeutic goal would be to attain greater separation between them. After that task has failed, since the mother is obsessed with "doing for" her daughter, a paradoxical framing would be to tell the mother that she is not attentive enough to the child and in fact she should consider expending greater effort and more devotion. By making the suggestion so extreme, the hope is that the mother will spontaneously reject the therapist's instructions.

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This form of therapy appears deceivingly simple but is actually quite complex. It consists of three major techniques: redefining, prescribing, and restraining.

Redefining. For this process to occur effectively, the therapist must accurately unearth the behavior cycle around the symptom. Once that has occurred, the therapist redefines the behaviors to the family as positive. The behaviors then become viewed in terms of their positive intention rather than their negative effects. For this process to be effective, the therapist must actually recognize the positive and not see the family's resistance to change as malevolent.

When viewed positively, the symptom can be seen as a benevolent sacrifice on the part of the individual for the family as a whole. Anger can be redefined as caring (people who don't care are indifferent), suffering and pain become self-sacrifice, and distance and disengagement are redefined as attempts to encourage independence and autonomy. The redefining process also somewhat confuses the family and prepares them for the next major technique, prescribing.

Prescribing. In this process, the therapist assigns to the family the task of carrying out existing actions in a more exaggerated fashion.

Restraining. The therapist must identify with the family's fear of change and therefore caution them against the negative consequences of change and elimination of the symptom. Thus, the therapist acknowledges that although dysfunctional behaviors are not ideal, avoiding the potential risk of the alternative is worth the sacrifice of one member. For example, if the therapist believes that the adolescent's use of drugs prevents her from separating from her mother and protects her parents from confronting their dysfunctional and empty marriage, to simply eliminate the drug taking risks much greater consequences.

The therapist thus tells the family to change and not to change at the same time. The therapist must sincerely convey and believe both messages. If the therapist believes only that the identified patient is harming herself by taking drugs and the family is in fact sabotaging the therapy, the message will come across as sarcastic and condescending, and the family will not buy it. But the therapist can expand the camera lens and change the angle of the camera to see the family as the strategic therapist does, he or she will be able to begin to believe in the absolute sincerity and panic of the family and present the messages with sincerity and conviction.

The first task of therapy is to develop a hypothesis about the function of this cycle in the family; this theory will continue to be refined and reshaped as the therapy unfolds. For example, in Mary Landau's family the therapist first must discern the sequence involved in Mary's use of drugs.

For example, Mary and John have an argument before he goes off to work. He leaves, telling her that he just doesn't have time to go into it again. → Feeling abandoned and frustrated, Mary takes a Valim. → Sensing his mother's condition, their son doesn't come home from school and hangs out with some neighborhood kids who smoke marijuana and participate in antisocial activities. → The "good" daughter comes home and tells mother about the son's transgression. → Mother praises her. → When son comes home, mother turns her out-of-control wrath onto him and he protests and runs out of the house. → Daughter is frightened by this and calls her grandmother (John's mother), informing her of the situation. → Grandmother calls John. → John comes home (the hero) and chastizes Mary as another "child out of control," collects his son and calms him down, thereby equilibrating the situation until it is exacerbated again when John and Mary have an argument about John being more available to his mother and job than to his family.

The intervention begins by positively redefining the sequence, underscoring the valuable function of each person's behavior. For example, Mary's taking Valium helps her deal with her loneliness and feelings of abandonment and serves as the central point around which all of the following behavior revolves. Their son's "acting out" allows the daughter to be the helpful, praiseworthy child, who never has to be seen as "having problems." Mary's quasi-abuse of her son allows her daughter to call her grandmother. Grandmother, who herself is married to a "problem" drinker, quickly calls her son, who was himself a "praiseworthy child." This allows grandmother to "get reinvolved with her son" and gain some distance from her own difficulties with her husband. Finally, the scenario allows John to disengage from work and be seen as a hero by his family, while maintaining his close relationship with his mother. It also allows him an excuse for his own difficulty in meeting his sales quota at work; John's accounts have not been doing well lately.

The beginning hypothesis can then be embellished when it is turned into the actual prescription. For example, Mary's sensitivity to John (demonstrated by her being incompetent) allows John to feel himself to be a "good" husband and father to his son, although he is rarely home. He certainly feels that he is better than his own father, who was abusive to him and his brother. Mary (who cannot stand her intrusive mother-in-law) gives her mother-in-law an opportunity to get more involved with her, her husband, and her family--at a tremendous sacrifice to herself and her relationship with her children.

Therefore, if Mary were to stop taking Valium, all of the above might have to change. The therapist is concerned about that potential change. Although things are bad as they are, the alternatives might be disastrous. For example, if Mary stopped taking Valium and acted more competently, John might not have an excuse for protecting his son. Then he might need to consider that he is not a much better parent than his own father.

Although the above example is a streamlined version of a strategic prescription, it nonetheless captures the essential process and the underlying logic. The therapist (sometimes alone and sometimes in conjunction with a team or cotherapist) unfolds the behavior sequences by carefully tracking answers to critical questions. On the basis of that sequence, potential hypotheses are generated as to the function of the particular symptom. Interventions are created on the basis of those hypotheses; the response to the interventions serves to modify the hypotheses. Prescriptions are usually given at the end of the session with no discussion allowed by the family. Sessions are often spaced 2, 3, or even 4 weeks apart to give the family an opportunity to respond fully to the intervention. If the family does not recoil from the prescription, the therapist has to determine whether the hypothesis was inaccurate or the intensity of the prescription was not sufficient.

ROLE OF THE THERAPIST AND THE THERAPEUTIC TEAM

Strategic communication therapists advocate the use of a team approach. The rationale is based on a different concept of cotherapy than is found in the multigenerational approach.

The team could serve as a Greek chorus, positioned behind a one-way mirror, providing a running commentary on the process taking place between therapist and family. Papp noted "that at the therapist's discretion, the group can be used to support, confront, confuse, challenge, or provoke the family, leaving the therapist to agree with them or oppose them" (Papp 1980, p. 49). The team does not communicate directly with the family but sends messages to the family via the therapist, who is either called out of the room by the team or leaves at a predetermined time near the end of the session.

The group can potentially support the family against the therapist, saying, for example, that John (in the earlier example) was not as weak as the therapist thought and they did not think he needed Mary's drug abuse to be involved with his family. Alternatively, they could deliver the prescription and the therapist could join the family, arguing for the family's capacity for change. This variety enables the therapeutic system (i.e., the therapist and the team) to present the family with the different alternatives and through anger, challenge, and other ways propel the family into change. The therapeutic system, made up of the team members pitted against the family, is engaged in a strategic battle whereby change is encouraged by relying heavily on the family's active and persistent resistance to that change.

In this model, the therapist is seen as a technician or engineer; s/he is able to stay aloof from the family, assess the cycle maintaining the symptom, redefine it, and prescribe it in such a way that the family rejects the intervention (their ongoing behavior) and "spontaneously" changes. A mystique is involved in this form

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of treatment; it appears that if one can come up with exactly the right intervention, the family has no choice but to change.

In fact, these interventions are extremely difficult both to create and to impart. They require skilled therapists or intensive and competent supervision. These interventions further require a conviction that the family is operating from a positive stance and the ability to convey that conviction sincerely.

Strategic therapists try to keep the therapy as short as possible. They believe that their insistence on a specified number of sessions (typically 10) keeps both the family and the therapist accountable for outcome. They feel that maintaining a clear problem focus should achieve results rapidly, and further issues can be renegotiated between the family and the therapist. They also argue for the economic validity of rapid treatment, enabling more people to seek help at less cost.

STRUCTURAL APPROACH

ORIENTING PRINCIPLES

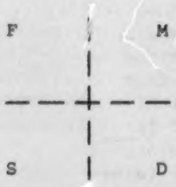
Conception of the Family. People operate within a social context, according to Minuchin (1974). Therefore, to understand any one individual's behavior, it is necessary to first understand the social limits imposed on that person. Although people participate and belong to many groups, the institution that has most to do with imprinting self-hood and bestowing identity is the family. For Minuchin, the family is the cradle in which we all grow and develop. As such, we move from being totally enmeshed in the family to a position of relative independence. The sense of belonging to one's family and the role played in it is a lifelong process. We will always be daughters or sons to our mothers and fathers and mothers and fathers to our children, regardless of changes in our other identities.

A hallmark of Minuchin's model is his assertion that a normal family cannot be distinguished from an abnormal one without the presence of an identified problem. Therefore, he presents a model of the family and of human beings that does not arbitrarily separate the world into "them and us." His conception avoids the labeling and stigma-producing processes so common among more traditional approaches.

For the structuralist, the family system has three major components: (1) it has structure, (2) it develops over time, and (3) it has the capacity for adaptation.

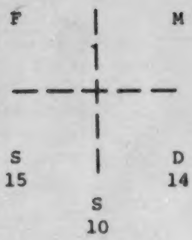
Structure. Family structure is "the invisible set of demands which organizes the ways in which people act. . . . Repeated transactions establish patterns of how, when and to whom to relate, and these patterns underpin the system" (Minuchin 1974, p. 51). As can be seen, this definition of structure is similar to the strategic communication concept of patterned sequences. There are many conceptual similarities in these two approaches, although they are not identical. As an example, the strategic communication approach is behavior-specific when it identifies a sequence of behavior and attends to sequence patterns. When the structuralists identify a similar sequence, they will additionally characterize it as a piece of a more general concept known as family structure. The structure is then mapped according to concepts such as boundaries and subsystems. The mapped structure then serves as the blueprint for guiding therapy. Before giving an example of mapping, we must define three concepts involved in structure: subsystem, boundaries, and level.

Subsystems. Since the family as a whole is considered a system, parts of the system are defined as subsystems. Subsystems are organized according to both membership and function. For example, all of the males in the family can be thought to make up a subsystem of males (membership); the parents (husband and wife) make up the parental subsystem (function). In fact Minuchin (1974) states that each individual can also be considered a subsystem. Although there are many possible ways of organizing the family into subsystems, a general guide is to divide the families according to generations in one direction and individually in another. For example, if M = mother, F = father, S = son, and D = daughter, a family of four would, according to the above, be organized as follows:



Notice that mother and father are placed above their children, which leads us to the second concept--level.

Level. For Minuchin, level denotes authority. Of all the subsystems in the family, Minuchin considers the parental system the most important. He labels this level the executive subsystem, which must make the decisions that guide and support the family as a whole. Accordingly, adolescents have greater authority by virtue of their age and autonomy than do preschoolers, and so would be placed atop younger siblings as below (the numbers refer to the ages of the children).

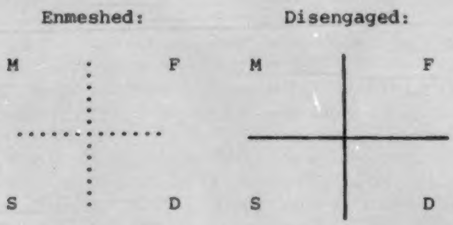


Boundaries. The boundaries of a system are the rules defining who participates and how (Minuchin 1974). When we talk about boundaries, we are talking about the clarity of the divisions between subsystems of the family, particularly the parent-child subsystem (but the husband-wife boundary is also important). The structuralist evaluates this clarity carefully when approaching a family because it provides the single most important indication of family functioning. Boundary clarity (Minuchin 1974) can vary on a continuum from overly rigid or disengaged at one extreme to overly diffuse or enmeshed at the other extreme. The terms rigid and diffuse refer to the clarity between family subsystems and the terms disengaged and enmeshed refer to family style. Rigid and disengaged are equated because disengaged boundaries are difficult for members to cross, so family members become overly distant from one another. Enmeshed boundaries are crossed too readily, however, and are therefore labeled as diffuse because people do not have enough distance from one another to function appropriately (see figure 2). The primary functions of a family are to allow for separation and autonomy as well as to provide support and nurturance. The clarity of the boundaries is crucial in both of these arenas. If the boundary between subsystems is too permeable (diffuse or enmeshed), then the subsystems are not sufficiently separate. In such cases, support and nurturance are provided at the expense of autonomy and independence. If they are too impermeable (rigid or disengaged), they are thus too separate; in that case, autonomy and independence are provided but this time at the expense of support and nurturance.

As mentioned above, enmeshment/disengagement refers to family style as well as boundary clarity per se. When a family style is referred to as "enmeshed," it means that the members are extremely responsive and reactive to one another; space and distance are hard to attain. In this type of family, when one sneezes, the other members of the family bump into each other to offer a tissue. These families are often characterized as being "into" each other's thoughts and feelings; they often talk for one another, complete each other's sentences, and generally "know" what the other is thinking. In enmeshed families, open expression of conflict is sometimes difficult and alternative means are sought. The family with the adolescent daughter who takes drugs as a way of separating from her mother is probably an enmeshed family; the adolescent chooses drugs as a way of expressing conflict without dealing with the actual issues involved.

In a disengaged family style, family members are overly distant and removed from each other. In this style, it is extremely difficult for stress in an individual to reverberate across the family subsystems. For instance, the parents of a child who is flunking out of school or dying of narcotic abuse may not get sufficiently worried to take action.

If we were to map these family styles they would appear as follows:



At different times, most families need some boundaries to be more or less unclear, particularly at times of developmental shifts. According to the structuralists, however, chronic operations at the extremes (disengaged and enmeshed) indicate areas of possible dysfunction and are attended to immediately when the family seeks therapy (Minuchin 1974).

Adaptation to Stress. Both the structural family therapist and the strategic communication therapist consider the family system to be homeostatic in nature. They see pressure for change coming from two general directions: (1) from within (as the family develops over time, rules and subsystem changes are necessary, e.g., shift to adolescence); and (2) from without (when external pressure, e.g., unemployment or moving, forces the family to accommodate and change).

The family is a "social system in transformation" (Minuchin 1974); it is never truly stable and always needs to maintain a balance between the larger and smaller contexts in which it takes part. A family in pain or stress at transitional points is not considered problematic or pathological. When there are demands for change from either within or without and the family cannot change, a therapist must "become an actor in the family drama" to help them move to a new level of integration.

ROLE OF THE THERAPIST

The structural therapist is an active insider and becomes an important member of the family and the leader of the therapeutic system. We must underscore that the therapist must become involved with the family in a very human way and use that involvement to maintain a position of leadership. Leadership requires maintenance of flexibility. Structuralists assume that problem families have rigid, stereotyped positions and transactional styles, and that it is this quality that prevents them from changing. If the therapist also loses flexibility, his or her behavior, like that of the family, becomes rigid; thus the therapist, loses his or her leadership position and becomes ineffective. The map of the family and the therapist's subjective thoughts and feelings are the primary tools (of course, a videotape and a good supervisor are also helpful). Because of this, many authorities consider structural work to be the most demanding but also one of the most effective of all therapeutic systems (see Gurman and Kniskern 1981; Minuchin et al. 1978; Stanton 1979a).

Again, authors concerned with gender issues in family therapy have characterized the therapist's style as masculine, especially as described by Minuchin in his earlier works (Gurman and Klein 1980; Hare-Mustin 1978). Little research has explicitly examined the reactions of families to a woman therapist or a less masculine style, but it is clear from work in other forms of therapy that different reactions are likely (Bernardez-Bonesatti 1978; Reed 1981), many of which will expand the gender-role assumptions within the family.

THERAPEUTIC PRINCIPLES

The three primary therapeutic principles include assessment, joining, and restructuring. Although these principles are interdependent, we will describe them separately. Both assessment and restructuring depend on joining, so we will deal with this first.

Joining. Before assessment and restructuring (planned change) can occur, the therapist must join the family; in fact, structural family therapy hinges on the ability of the therapist to accomplish this. The joining process involves the therapist making personal contact with each family subsystem. In the process of joining, the therapist often seeks to make each member of the family a temporary cotherapist (using his or her position to support that of the therapist). As this happens, the family member's status is reinforced, and the therapist's status as an insider and leader becomes reinforced (see Minuchin 1974, chapter 7, for a fuller discussion of joining).

Assessment. Assessment involves the therapist making a working hypothesis of the family structure. This assessment is not considered an objective final statement or diagnosis made after a series of interviews, but rather as an ongoing process in which

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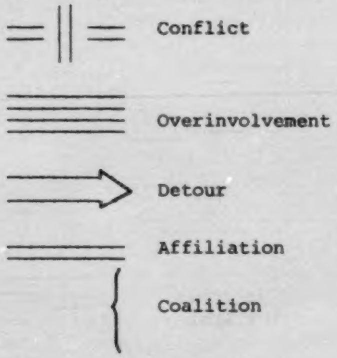
the therapist attempts to change the family and the family attempts to change the therapist. The responses to the therapist's probes and interventions make up the assessment.

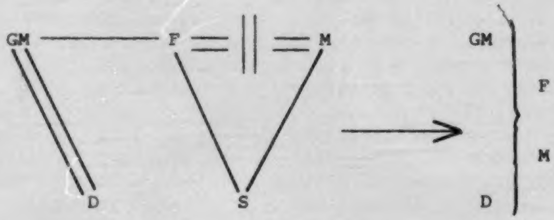
The family map is used as a tool to assist the therapist in organizing complex and diverse information. It is not considered as a final, true statement of the family but only as a working aid. The following notations are added to the ones described earlier (for precise definitions, see Minuchin 1974):



The following story illustrates how these symbols are put together to develop a map.

In the Landau family, Mary, John, John's mother, Johnny, and Susie are seated in the therapy room. The therapist inquires: "What can I do for you?" Mary starts talking, relating that John is never at home and is more involved with his mother and his job than he is with her. As this is going on, Susie is visibly uncomfortable. John's mother interrupts Mary and signals Susie to start talking. Susie then relays that mother has a problem with drugs and is abusive with Johnny.

At this point the therapist has the beginnings of a map. Mother and father appear to be in conflict and grandmother has entered into a cross-generational coalition with Susie against mother. This detours the conflict between parents and identifies the problem as residing inside Mary.



This process has the added consequence of elevating Susie to an authority equal or superior to her mother and places grandmother on an equal level with her son, John.

The therapist makes the hypothesis and wishes both to evaluate it and test the flexibility of the family's internal boundary, so she imposes a rule that no one is to interrupt and asks Mary to continue. Mary looks visibly shaken and starts to sob about her drug taking. The therapist suggests that Mary should continue with her opening remark about John, and as Mary begins to talk, Susie interrupts again, this time asking her if she would like a tissue. The therapist thus has additional information. First she is aware that the patterns in the family are resistant to change. Were they flexible, Susie would not have interrupted again; Mary or John would not have permitted it and Mary would not have accepted grandmother's and Susie's definition of the problem (need).

The therapist now asks Mary to tell Susie not to interrupt her. As she turns to do this, Johnny immediately interjects, defending his sister by saying that she was just trying to be helpful.

The therapist laughs and says, "This is very interesting, this is beautiful. John, why do you think your son and daughter are disrespectful to your wife and won't let her answer my questions? I want you to help her so that she will be able to do this. However, I want you do to this in such a way that she tells the children and not you."

The therapist in this sequence has done several things. First, she contacted both Mary and John, imposed rules, interrupted transactions, and gave directives to family members. In addition, as part of the assessment procedure, she has initiated changes in the family's structure. In this regard the therapist has begun to bring John and Mary together by asking John to help his wife so that she can enforce a more appropriate boundary with her children. This would have the effect of elevating Mary in the authority structure.

The therapist has many options when interviewing a family. In the above situation, instead of asking John to help his wife, the therapist could have asked Mary to discuss the issue with the children: "Why are they disrespectful to you and why won't they listen to you?" In this case the therapist has a hypothesis that has been substantiated--the reason the children do not listen to and are disrespectful of mother is because grandmother and possibly father enter into a cross-generational coalition with the children and elevate them to a position equal or superior to their mother. This makes Mary incompetent and gives the children the false status of being a parent to their parent. This clearly a violation of subsystem boundaries and is not good for the children, Mary, John, or grandmother. Although the therapist has a hypothesis and a plausible explanation for the interaction, you should notice that she does not just tell the parents what she has observed. Rather, by turning the problem back onto the family, she begins to expand their vision of the problem. Structuralists refer to this type of intervention as creating a workable or therapeutic reality (see Haley 1976; Minuchin 1981; Montalvo 1976). The "reality" that the family brings to therapy (e.g., mother is chemically dependent; father is never home; grandmother is meddlesome) is such that it keeps the family from changing. Each member feels blamed and therefore attacks the other in a series of frustrating and unproductive interactions. The therapist, by not participating in that no-win situation, helps the family start to see a different type of problem. The therapist does not create this problem because it has been there all the time; the family members begin to experience their problem differently, however, through the therapist's participation in the family and so are in a better position to change it.

The first few minutes of a therapy session therefore contain a wealth of information. The structuralist participates in order to organize the information and then transform it into a new picture of the family. What is important to remember is that as the therapist participates with the family, s/he actively uses the family's input, so that the picture the therapist presents is always one that belongs to and can be accepted by the family as being theirs.

Restructuring. Because things happen very quickly even in the first moments in structural therapy, the processes of joining, assessment, and restructuring do not follow in neat, discrete stages. What is also apparent is that the map presents the therapist both with a goal and a therapeutic direction. In the Landau family, for example, we have some idea of the initial family structure. How would we like to see that structure at the termination of therapy? Part of the answer depends on further information, which the family will provide as a result of their reaction to attempts to change them. This important concept underscores the role of the structural family therapist. As an insider, the therapist challenges other family members to push the family beyond its usual operating limits. The degree of reaction, panic, or desperation signals to the therapist the degree of flexibility with the particular system. The more rigid the system, the stronger the reaction. Thus the therapist encourages counterbalancing feedback.

The therapist with this family will need to know to what other systems grandmother is connected. An axiom of structural family therapy is that a person cannot disengage from one subsystem without being engaged in another. The therapist will also need to experience the nature of the spouse conflict: How supportive can John be of his wife as she attempts to stop using tranquilizers? Of course, more information must be gathered and will be obtained as the therapist attempts to restructure the family.

Restructuring techniques are the most exciting aspects of structural family therapy. Minuchin has identified six major classes of restructuring operations. Given the scope of this chapter, the two best-identified structural techniques--actualizing transactional patterns and marking boundaries--will be discussed; the other four will be mentioned briefly.

Actualizing Family Transactional Patterns. The structural family therapist is perhaps best known for having a family act out their family drama in the session. The family's real transactional patterns are beyond its members' awareness; therefore, any description of the family by family members is influenced by what they believe is the problem. The therapist who relies on the family's definition of reality accepts that reality, which in itself is part of the problem.

Nonverbal communication confirms or contradicts what the family says, so the therapist should pay careful attention to how people act. In the Landau family, for example, when mother was sobbing, Susie was visibly upset. However, when the therapist asked father to inquire how Susie was feeling, Susie told her father she felt fine. The therapist at this point knows that there are rules regulating what people are able to admit to each other.

In work with chemically dependent families, several enactments have been used to dramatize therapy. Some of these include observing the behavior of the family while members are "high" and giving Antabuse during the session. These enactments demonstrate how the families organize around the use of chemicals and how the family is different when the chemical is available. This enables the therapist to recognize what will be needed to eliminate the symptom (Steinglass 1977).

Less extreme enactment is achieved by directing members of the family to talk with each other rather than with the therapist. An example of this was seen in the interview with the Landau family when the therapist asked Mary to talk to her children about why they interrupted her.

Another well-known technique of actualizing transactional patterns is the manipulation of space. The structuralist is concerned with mapping the family in space. Location serves as an important metaphor for the closeness and distance that exist between people. For example, the therapist noticed that when the Landau family entered the therapy room, the children sat between mother and father, with grandmother flanking father's other side. As the session progressed and the therapist moved to having mother and father talk with each other, she asked the children to change seats: "How are mom and dad ever going to talk with each other and get things worked out if they can't even see or hear each other with you kids being in the way?" This conversation thus uses the metaphor of space, as well as the actual manipulation of the seating arrangements, to highlight the way in which the family is problematically organized.

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The structuralist uses an enactive style of communication. Rather than ask mother why her daughter won't listen to her, this therapist will ask her to talk in such a way that the daughter will listen. This style encourages and brings action into the therapy room.

Marking Boundaries. The structuralist is concerned with protecting each individual's right of autonomy and need for support. Each family's subsystem should have clear and flexible boundaries. The examples given to highlight certain enactments, therefore, can also be seen as marking boundaries and protecting the interactions between family members within key subsystems from interference by other family members (e.g., "How can mom and dad talk without interruption from Susie?").

Escalating Stress. All of the restructuring techniques mentioned have the effect of escalating family stress, a necessary component of change. Minuchin once said that crisis includes both opportunities and danger. Rather than fear stress, the therapist must encourage it so that change is possible.

Blocking Transactions. The therapist can always create stress by not allowing family members to use their normal channels of communication. In the Landau family interview, the therapist imposed a rule that no one was to interrupt. By blocking this maneuver, she did not allow the conflict (in this case between Mary and John) to be detoured through Susie.

Making the Implicit Explicit. Family members are rarely aware of the implicit meanings of their communication. Again, in the Landau family when the therapist asked the children to get out of their parents' way, and therefore their relationship, she made the implicit explicit, a move that is likely to heighten stress.

Selectively Joining an Alliance or Coalition. In this powerful yet dangerous technique, the therapist must be careful that s/he has the flexibility to change alliances should the family's tolerance for stress become too great. Even when the therapist joins one subsystem in the family in an attack on another, s/he must also be skilled enough to support the subsystem under attack. Minuchin refers to this maneuver as "kick and stroke." That is, each time a structuralist attacks a family member, s/he also provides support. For example, the therapist could help Mary attack her husband for not being more available and join in that anger, but the therapist could also interpret John's behavior as an attempt to assert his independence by resisting being told what to do. This also relates his behavior with his wife to his implicit struggle with his mother.

NETWORK ON ECOLOGICAL APPROACH

ORIENTING PRINCIPLES

An ecological orientation follows directly from the systems model detailed earlier. It seeks to explain behavior in an individual unit (person or family) by understanding the complex interchanges between the family and its environment. This approach differs from traditional family therapy in that it expands the boundaries of the system beyond the nuclear family to encompass the total community. In addition, it focuses precisely on the interfaces between systems and on communication processes taking place at those interfaces.

Auserwald (1968) stressed that an ecological approach makes it possible to identify the life areas in which an individual family or social network needs assistance. This approach can help therapists mobilize and coordinate the resources of the family and the community to help restore and stabilize the family. It does this by broadening the focus of intervention to the formal and informal systems in which family members interact. It also provides a framework to help various agencies coordinate their services rather than make separate, often fragmented helping attempts and conflicting demands on a given family.

An ecological approach may be especially important for women with few or stressful linkages to friends, neighbors, social agencies, or institutions. For instance, many women entering drug abuse treatment have many responsibilities and needs for services, have few people they can turn to for help, and have erratic or no relationships with relevant medical or social agencies that could help them financially, physically, and emotionally (Reed and Leibson 1981; Tucker 1980). Some women may have repeated encounters with the criminal justice system, protective services, their children's schools, or various health and emergency services. Each agency then tries to help the woman or a family member or to exert social control over behaviors society has defined as unacceptable (e.g., crime, child neglect). Some of the woman's family members may be trying to cooperate with an agency or have asked for help, while others may resent outside intervention. Without an ecological framework and coordination, this interdisciplinary approach is likely to make enormous demands on an already overstressed family and will exacerbate relationships and coping problems among family members. The therapist may also miss possible sources of support and stability among key friends or neighbors and perpetuate patterns of many concerned persons working at cross purposes.

There is no clearly identified therapeutic procedure associated with an ecological approach, but several authors have sought to create assessment tools. For example, Hartman (1972, 1978) has developed what she calls the eco-map. The map is constructed by the therapist as he or she interviews the identified family. Using the metaphor of energy exchange, Hartman builds a visual picture of the family and its relationships with its ecology by noting the mutual exchanges of concrete services and emotional support. Figure 4 shows a facsimile of Hartman's eco-map (an uncompleted map).

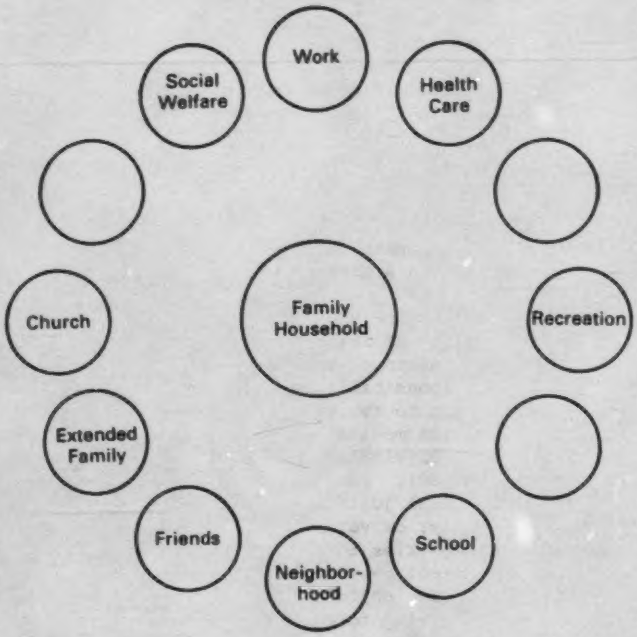
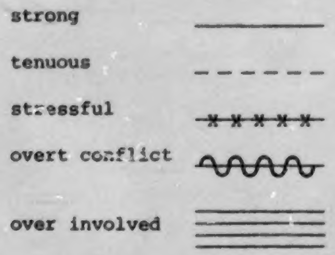

Work
Social Welfare
Health Care
Church
Family Household
Recreation
Extended Family
Friends
Neighborhood
School

FIGURE 4. Eco-map

On this map the therapist symbolically fills in the family's ecology. To paraphrase Hartman's instructions: In the center circle draw a picture of the immediate family using the same symbols as you did for the genogram (see figure 1). After doing this, ask about the family's relationship with each of the social institutions contained in the map. You can add additional categories that more accurately reflect a particular family. Indicate the nature of the relationship by lines. Examples Hartman gives are:



You can also draw arrows along the lines to indicate the person who initiates contact or the direction in which resources flow. Hartman encourages practitioners to modify the map to suit their own needs.

The ecological interviewer asks several important questions: Which institutions interface with the organism? What is their relationship to the organism? What are their relationships with each other vis a vis the client? And how can the process within the family be understood and interpreted in the light of these relationship systems?

Another advocate of the ecological approach is Hoffman (1977, pp. 501-519; Hoffman and Long 1969). Like Auserwald and Hartman, she views the client's problem as resulting at least partially from relationships to the larger social and caregiving systems. Because needed services are dispersed by separate and often uncoordinated agencies, clients who already feel powerless are often given conflicting instructions and expected to respond to many different assumptions and often ambiguous messages. In this model, then, the family becomes the identified patient. The ecological intervenor works to deemphasize the intervenor's power within the family while helping the family interact with community organizations from a position of knowledge and strength. Techniques are structured to bring about change on two system levels: the family and the caregiving agencies. This is accomplished by giving sensitive assignments to various family members, holding counseling sessions, and signing individual and joint contracts with professionals, all with the purpose of addressing problems that exist at the interface of the multiple systems involved.

It is not uncommon, for example, for families to be referred to therapists from multiple sources. Sometimes, as in the case of a child welfare referral for a child in foster care or a probation officer's referral because of criminal activity, each agency has the ear of the judge and each can influence him or her depending on how they see the problem and its correct solution. When these two individuals don't agree, a conflict is established that places the family and the therapist in the middle. Just as not dealing with conflicts between parents exacerbates the problems of a child, so too can the covert conflict of multiple agencies exacerbate problems for the therapist and the family. Therefore, ecologically minded therapists must shift their focus to address this specific problem. For example, the therapist could ask the family to invite the two agency representatives to a meeting, and s/he could support the client in asking for a clarification of what they expect of her. Sometimes a phone call or meeting between the professionals is sufficient. Whatever the action, the therapist's strategy should be based on an accurate assessment of the situation and should have the long-term goal of (1) freeing the client from the overinvolvement of multiple agencies, or (2) helping her deal more effectively with them.

An ecological framework, then, allows the therapist not only to understand the effects that family interactions and patterns have on individual members, but also how family dynamics are influenced by the larger extrafamilial institutions of kinship, neighborhood, friends, and community institutions. Ecological interventions might choose to focus on only a component of the larger system, to establish new relationships, to intervene with problematic interactions, or to coordinate conflicting or chaotic exchanges. In network intervention, the intervenors work on numerous levels at once.

NETWORK INTERVENTION

Social network therapists (Attneave 1969; Speck 1967; Speck and Attneave 1973; Speck and Rueveni 1969) assemble a family's total social network:

> . . . to stimulate, reflect and focus the potentials within the network to solve one another's problems. By strengthening bonds, loosening binds, opening new channels, facilitating new perceptions, activating latent strengths, and helping to damp out, ventilate, or exercise pathology, the social network becomes the life-sustaining community within the social matrix of each individual [Speck and Attneave 1973, p. 49].

After a thorough network assessment, the family is instructed to contact and invite their relatives, friends, neighbors, work associates, and significant helpers from churches, schools, social agencies, and institutions "who are willing and able to take the risk of involvement" (Speck and Attneave 1973, p. 20).

As the family therapist redefines a "labeled" individual as a family problem, the network intervenor redefines the presenting problem as the result of the alienation and the fracture of relationships surrounding the identified patient. The therapist sees the social matrix in which the family is embedded as the primary source of disturbance and the most powerful avenue for change.

Social network intervention is particularly successful in situations of extreme family stress and desperation and is not appropriate for all families. Some families request "a network" for themselves. Other logistics factors that influence the decision to enact a network are (1) proximity of potential members, (2) availability of professionals, and (3) the problem of getting the family to invite 40 to 50 people to the network meeting.

Network interventions generally do not last longer than 6 weeks. The therapy team helps to build problem-solving groups at the meeting from the extended family, neighbors, friends, and social agency representatives present, with the nuclear family in the middle. Speck and Attneave (1973) described a series of six stages, potential "stall" points in the process, and explained how intervention team members should organize and conduct themselves. A few specific areas are identifed to be addressed. Over time, a few "network activists" emerge who are willing to take responsibility for providing leadership and coordinating the efforts of other network members, often via committee structures. For instance, a client may need better medical or health care but has not followed through in seeking it. Activists might set up weekly meetings with her to help her set appointments and follow through on them. Eventually the treatment team leaves and the group or committees continue to work.

Callan et al. (1975) described network interventions for drug addict clients as they reenter the community from a residential setting. They list some of the key steps and procedures they have followed for readers interested in learning how to do this. Other types of network sessions educate and coordinate the efforts of people who care about the client and have some influence over her. Without this coordination, their efforts to help her are not effective and may even keep her from facing the effects her chemical dependency is having on her own and others' lives.

MULTIPLE FAMILY GROUP THERAPY

ORIENTING PRINCIPLES

Multiple family group therapy (MFGT) involves several families (usually three or more) who gather together to discuss common problems. Usually one or more members of each family have been identified by a psychiatric, legal, or social service agency as needing help of some kind. The groups vary in size depending on the number of families, cotherapists, and observers. MFGT draws on principles of both group and family therapy.

Data on the pretreatment history of chemically dependent women show that their non-drug-involved network of social relations has often been shattered. Interpersonal help often comes from friends who are also involved with drug use. These situations, combined with exhausted family resources, place the recovering addict in a dilemma. If she turns to friends for support, this involvement can lead to more rejection by her family. Barred from family resources, she may be forced to turn to often exploitive relationships for support. Faced with overwhelming survival needs, she may suppress negative feelings, concealing emotional and interpersonal needs which in turn lead to greater depression, loneliness, isolation, and perhaps a return to drugs. Given the above, it is not surprising to find many treatment settings using a form of MFGT because it seems to address the needs outlined above. Kaufman and Kaufmann (1979a) feel that MFGT may well be the best intervention for single parents with small support systems because it can lead to new "extended" family structures. MFGT has been successfully applied in both inpatient and outpatient settings (Bartlett 1975, pp. 262-82; Kaufman and Kaufmann 1979b).

MFGT has been particularly useful at the point of discharge from residential to outpatient status. The recovering individual, having recently spent from 1 to 12 months or more in a community established to support breaking the dependency cycle, is suddenly thrust into settings that have come to expect her to be incompetent. Although the family does not purposely set out to sabotage the gains made in treatment, the integration of this individual back into the family network is often difficult. Meeting with other families that share this dilemma in an atmosphere of mutual support allows the family to reorganize itself around a "nonpathological individual" so they are neither too tentative with or overreact to her when she returns to the family.

The multiple family group setting also supplies direct peer support for the recovering individuals, who are also undergoing a similar transition process. Curry (1966) noted that many multiple family groups break down into smaller ones and that these smaller groupings are not necessarily organized around family boundaries. Many subgroups will form around "fathers," "mothers," "patients," or "adolescents." These smaller groupings both push their members for change and offer support and protection.

MFGT has also proven to be valuable before termination in residential programs and in more traditional outpatient programs. These groups encourage previously "burnt out" families to try again for their female members and to get something for themselves in the process. This approach can counteract the one-way flow of resources from family to "addict." A second reason the groups are valuable is that they begin to reverse the isolation characteristic of female addicts and their families. Members of the group often meet outside the treatment setting. They exchange information; services such as babysitting, shopping, and home repairs; and accompany each other to medical and social service appointments. It is also not uncommon to find families socializing with each other, either as individuals, couples, or whole families. This aspect of the support function served by the group has led some observers (e.g., Laqueur 1972) to consider that MFGT supplies functions similar to more traditional therapeutic self-help groups, such as Parents Anonymous, Alcoholics Anonymous, and Women for Sobriety.

Because the MFGT combines aspects of group and family therapy, several researchers have suggested that it is superior to either modality. For example, Lewis and Glasser (1965) noted that by combining patient and family groups they were able to break each family's need to maintain rigid family myths. This is extremely important in challenging and evaluating the deviant role played by the addicted individual. In reviewing Lewis and Glasser's work, Strelnick (1977) suggested that the rules of the therapeutic group conflict with the rigidity of the families' rules, such that as the group grows in size, the importance of individual family rules diminishes. "Large groups," Strelnick (1977) wrote, "concentrate on behavioral adjustment, social learning, and problems of communication, while smaller groups tend to focus on more individual problems."

Advocates of MFGT stress that by combining family units in therapy, the focus is more easily widened to spotlight the family as the treatment unit and not just the individual. Helping the family to make this shift is one of the most difficult processes in all family therapy, especially when the client (in this case, the chemically dependent woman) often cooperates with her family's view that she is the problem. If Strelnick is correct, then MFGT should be a seriously considered treatment choice for chemically dependent women.

GOALS

The general goals of MFGT can be summarized as changing family interaction and increasing the family's awareness and sensitivity to its environment (Strelnick 1977). Within this general goal statement, others (Curry 1966; Laqueur 1970) have identified more specific goals: (1) more efficient use of staff time; (2) involving the family in the "patient's" treatment; (3) placing the problem "in" the family as opposed to "in" the identified patient; (4) increasing insight (Kimbro et al. 1967); (5) reducing the family's source of stigma and isolation; and (6) providing the identified patient with support and reducing her isolation.

When attention is turned to the therapy team itself, most, if not all, reports of MFGT advocate the use of cotherapy teams. Kaufman and Kaufmann (1979b) have suggested the use of up to five therapists in a program combining multiple networks. For the most part, treatment teams are generally made up of two therapists, who first must provide the therapeutic group with (1) support, (2) a nonjudgmental atmosphere, (3) stimulation and expression of problematic communication, (4) encouragement to verbalize, and

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(5) reality testing. Second, as we have indicated with other advocates of cotherapy, cotherapists must provide a model for families through their own interaction with each other. Finally, cotherapists must develop introspection in the families by (1) focusing on *how* members of the group relate, (2) pointing out whether family interaction achieves its goals, challenging them where it does not; and (3) encouraging alternative behaviors (Strelnick 1977).

GROUP STAGES

Although many actors describe the therapy process in idiosyncratic terms (Kaufman and Kaufmann 1979*b*; Laqueur 1972), the MFGT generally goes through a series of specific stages. Blomfield (1972) has identified four group stages--pregroup, second, third, and fourth.

Pregroup Stage. During this phase the group is still ordered by their previous organization and has not evolved its own structure. This stage is characterized by much joking and greeting, polite behaviors, and laying down ground rules. The focus is still on the individual patient, and generally family members speak about each other rather than directly to each other.

Second Stage. This stage is characterized by the emergence of peer group support, which occurs around the third to fifth meeting. Members of different groups (e.g., parents, male siblings) may meet together rather than with their families. This stage marks the beginnings of cross-generational dialog. The peer groups, who are now giving support to each other, begin to confront and challenge other groups so that anger and hostility appear, which reveals role and power struggles in the families. When working with the families of chemically dependent women, therapists must be aware of their own biases concerning women's issues. Many women writers go a step further (Babcock and Connor 1981; Corrigan 1980; Hare-Mustin 1978) and advocate that the therapist must challenge the limiting nature of women's roles and family identities. Finally, at this stage there is an erosion in the distinction between "sick and well."

Third Stage. This is the period of greatest intensity and activity. During this stage crises generally occur that lead to an organizational restructuring in the family. Hidden marital problems may emerge. Overt confrontation occurs, and the groups become less dependent on the cotherapist teams and increasingly assume leadership for structuring their goals and providing their support.

Fourth Stage. This stage is characterized by a consolidation of gains made during the sessions. The reorganization of each family is supported and reinforced, and a more functional homeostasis should have been reached.

Most persons who have written about MFGT do not promote a specific model of treatment; in fact, they have implied that the group itself provides the necessary structure for therapy. Also, most writers tend to assume that therapists are familiar with both group and family techniques and that they can simultaneously track the progress of the group as well as of each family. Earlier we indicated our bias against eclecticism for beginning family therapists, and that is perhaps our greatest ambivalence about MFGT. Our second caution is the assumption that one should rely on a group structure to supply the expansion of the initial problem to a family problem. We believe that this skill must be mastered by each family therapist in any setting, whether with 1, 2, or 15 families.

Finally, several writers have noted that there has been little research on the effectiveness of MFGT (Laqueur 1972; Strelnick 1977). Although proponents strongly advocate its superiority, preliminary data suggest that MFGT is not necessarily superior to more traditional family therapy (Strelnick 1977). Given the state of outcome evaluation in family (and other types of) therapy, however, some chemically dependent women and their families are likely to be better served by this approach. We have noted, for example, the importance of reducing stigma and isolation and of counterbalancing family burnout. In conclusion, we encourage therapists to experiment with MFGT and evaluate it personally.

As a summary, table 2 abstracts the major information regarding the above models. A similar chart was developed by Bermann (1974) several years ago.

WHAT THERAPISTS CAN DO TO GET STARTED

The success of this chapter can be measured in the numbers of people who want to change what they do as a result of reading it. Hopefully, those who are not already involved in work with chemiically dependent families, will give more consideration to the possibility of applying this approach with families of women clients. Others may have encountered new ideas that can be incorporated into their work.

Therapists should think about the people they are seeing and the problems they present, and they should ask the following questions: Are they victims or are they victimizers? Are they neglectful of their family or are they being neglected by their family? What labels have been given to them? Can you see them differently now? Can you think of questions that you want to ask that weren't important before? How is the victim not a victim? How is the victimizer helpful? When they neglect their families, who steps in and fills their shoes? What would this helpful person do if s/he wasn't needed?

The questions are unending, once the camera moves ever so slightly to allow more of the background to become foreground; we give up

TABLE 2.--Family therapy models

	Multigenerational					
Variation	Bowen	Intensive	Strategic	Structural	MFGT	Eco-Network
Activity of therapist	Passive outsider	Passive outsider	Active outsider	Active insider	Active outsider	Active outsider
Flow of communication	Therapist to family	Between therapist and family	Therapist to family	Between family and therapist	Between families	Between agencies, family, etc.
Counter-indications	None against	None against	None against	None against	None against, good with isolated	None against, good when multiple systems involved
Therapeutic unit	3 or 4 generations	3 or 4 generations	Nuclear family or active family unit	Nuclear family or active family unit	3 or 4 families (or more)	Friends, neighbors, family, other agency staff
Number of therapists	1	2	1-4	1	3-5	1-5

TABLE 2.--Family therapy models--Continued

	Multigenerational					
Variation	Bowen	Intensive	Strategic	Structural	MFGT	Eco-Network
Significance of history	Great	Great	Little	Little	May be great or little	Little
Relation to exterior	Extended family	Extended family	Little	Little	Other family	Natural environment
Duration	Long term (more than 1 year)	Long term	Short term (less than 1 year)	Short term	Short to long	Short
Location	Therapist's office or counseling room	Therapist's office	Therapist's office	Therapist's office	Therapist's office	Family home or related hall

some individual detail for a larger picture. As the picture expands, the therapist's work will vary--the "sabotage" of the progress made by the chemically dependent person by family members becomes more understandable and more predictable. As we understand the system and the importance of the symptom to the system, we become less angry at the saboteur and become more inventive in ways to make that person a part of the change.

In working with the families and networks of chemically dependent women, therapists must remember that drug and alcohol treatment programs have, for the most part, been organized for chemically dependent men. We now know that men and women in the same facility do not necessarily receive the same services. A family therapist may also share limiting cultural views of women's (and men's) appropriate roles and be less sensitive to alternatives that might be more adaptive in some families or more fulfilling for some women (Hare-Mustin 1978).

Family therapy, in and of itself, will not counteract a setting that has different standards for women or a therapist who lacks gender sensitivity. But family therapy can, if applied with sensitivity to the chemically dependent woman and her family, make a unique contribution. The woman who is chemically dependent is likely to be pivotal in the family situation because one of a woman's roles is to be responsible for the welfare of her family. If things go wrong, she is likely to be blamed and may be burdened by guilt. Women who are chemically dependent feel and are thought to be "worse" than men in the same situation (Colten 1980) and are less likely to be supported by others as a result. Thus, when working with the family of the chemically dependent female, therapists must pay special attention to the potential of misinterpreting the problems forced on her as originating "in her." For this, therapists may need additional training in family therapy. Therapists should also be vigilant about the sensitivity of the training program and trainers to gender differences, the consequences of stereotyped roles, and the implications of status differences between men and women.

A list of training institutes and programs available in the different perspectives appears in the appendix. Therapists with limited resources can locate workshops given by experts both locally and at greater distances, or they could contract with a knowledgeable person for in-service training at the agency.

If funds are limited, therapists may have to be more creative. Perhaps they can exchange training sessions with another agency that does family work or agree to provide educational experiences for students in exchange for some staff training by college or university faculty knowledgeable about family work. Therapists might also arrange to observe others who do family work or volunteer some time in a family agency to take advantage of their in-service training. Just beginning to think differently about your clients will affect how you work with them.

Ongoing supervision should be a central component of any family therapy work whenever possible. It helps to develop a support group among persons within the agency who are interested in family work, or as one famous family therapist put it, form a "cuddle group" that will hold up therapists when families let them down and help sharpen their thinking along the way. The cuddle group can become instrumental in helping therapists plan interventions and avoid being seriously incorporated into the family system. It can also help therapists cope with feeling alone, depressed, or ineffective, all of which are unavoidable feelings from time to time. Therapists must also build in procedures for regularly examining assumptions about gender to guard against inadvertently reinforcing roles and behaviors that are limiting to either women or men.

As an agency begins to work with families, it will need to deal with various administrative issues, including how to "count" the time therapists spend with family members. The agency also needs to develop mechanisms for involving the families. Remember, families don't think they're the problem, and they might get angry at anyone who implies that they are; they may not want to "drag the children into this mess"; they "may not care about what happens because they're sick of caring." And they may come up with all sorts of inventive reasons not to come in. The client is also likely to be ambivalent about involving her family. Chemically dependent women are often depressed and have low levels of self-esteem and thus may feel unworthy of their families' concern and guilty about involving them further.

Although the task of involving families is difficult, it is not impossible. Some therapists use the metaphor of a "team," with the therapist playing the role of coach. Family members are seduced into treatment as key team members needed to plan the game (Napier and Whitaker 1978). Stanton used the client's motivation for treatment as a way to get their families to participate in therapy. When clients request treatment, they are first approached with the idea of involving their families. Once the patient agrees, the therapist must make direct contact with the family rather than through the patient. Often the therapist talks to each reluctant family member individually to invite each to be of help to the therapist in his or her work (Stanton and Todd 1979, in press). This approach often works better than working through the client, who is reluctant to have anyone else involved. For example, client and spouse have just had a fight, which is unresolved, and the client says, "My therapist wants you to come in next week." No self-respecting spouse would respond positively to that invitation, but the client will tell the therapist that she invited her spouse. Stanton has had impressive results, with over 80 percent of the extended family participating.

If a direct appeal to family members doesn't work, it is sometimes possible to work with the relevant agency to require participation by the entire family. Most court or protective services referrals are for the client only and not the family, but this practice can be modified. This approach requires a lot of legwork and follow-through with the relevant agencies to keep it going, but it is powerful when it works. Remember, however, that people do not like being forced into doing something. If an agency will supply enough muscle to force family participation, the chances are that when the family does come in, they will be very angry at the therapist. At this time, it is important for the therapist to keep the issue between the agency providing the pressure and the family, with his or her own position as neutral as possible. This will help the therapist differentiate from the community that has defined the family and the client as being deviant. As a last resort, a therapist might even refuse to see the client unless the family comes in (with a lot of agency support, of course). There are probably as many ways as there are therapists. The more convinced therapists are of the need to have family members present, the more inventive and successful they will be in getting members involved.

We close with a final caution--just as therapists should not move too quickly with new strategies, they also should not frighten and alienate clients and their families by being too quick to take away the problem from the family member who is the "patient." Giving up a problem is often as difficult as accepting or living with it. The skill of the therapist in helping the family to work on issues they can talk about (e.g., conflict, parenting, coordination) enables the problem to be framed in a different way. The therapist cannot convince the family that it needs the chemically dependent member to abuse substances; rather, the family members must convince the therapist and the "client" that they no longer need to be dependent on chemicals.

APPENDIX
SELECTED TRAINING RESOURCES FOR FAMILY THERAPY

Within the chapter, you were cautioned about assessing the gender sensitivity of any family therapy training program. Many such training programs also have little knowledge of how to include chemical dependency patterns in an assessment or of dynamics and issues particular to chemical dependency in families. You can still learn much about family therapy techniques by attending their training programs, but may need to adapt what you learn to be consistent with your knowledge of chemically dependent families.

The following is a brief list of institutes and organizations that offer ongoing training in family therapy. A much longer list, which also includes programs in academic and other settings, can be found in "Family therapy training: The institutional base." *Family Process*, 20:131-166, 1981. Journal address is: 149 E. 78th Street, New York, N.Y. 10021.

Ackerman Family Institute
149 E. 78th Street
New York, N.Y. 10021

Behavioral Sciences, Research and Training Department
Eastern Pennsylvania Psychiatric Institute
Henry Avenue and Abbottsford Road
Philadelphia, Pa. 19129

Boston Family Institute
1170 Commonwealth Avenue
Boston, Mass. 02134

Center for Family Learning
10 Hanford Avenue
New Rochelle, N.Y. 10805

Center for Family Learning
8740 N. Kendall Drive
Miami, Fla. 33156

Family Institute of Chicago
Ten East Huron
Chicago, Ill. 60611

Family Therapy Institute
4602 North Park Avenue
Chevy Chase, Md. 20815

Menninger Foundation Family Therapy
Training Program
Topeka, Kan. 66601

Mental Research Institute
555 Middlefield Road
Palo Alto, Calif. 94301

Minnesota Family Study Center
218 N. Hall
University of Minnesota
St. Paul, Minn. 55108

Philadelphia Child Guidance Clinic
Two Children's Center
34th & Civic Center Blvd.
Philadelphia, Pa. 19104

The following is a chemical dependency training program with strong family emphasis. Wegscheider works from here:

Johnson Institute
10700 Olson Memorial Hwy.
Minneapolis, Minn. 55441
(616) 544-4165

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Childcare Support Services for Female Clients in Treatment

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This chapter addresses the issue of how treatment programs can offer quality child day care services to chemically dependent women through linkages to public and private community day care services.

Although women who use drugs have unique problems and needs related to their drug dependency, as mothers they share a common responsibility--childrearing. These women must face interactive and often competing demands. The responsibility for the 24-hour care of small children usually does not allow a drug-dependent woman the freedom to pursue needed medical services, educational pursuits, vocational training, or satisfactory employment. Moreover, studies have shown that a woman's drug dependency may affect her ability to adequately care for her children. Both research and clinical experiences have indicated that illicit drug use leads to problems in female physiological functioning, poor pregnancy outcomes, and inadequacies in fulfilling the parental role (Finnegan 1979). The responsibilities of parenting require a considerable amount of time and energy--factors that may be seriously diminished by a woman's dependency on drugs. As a result, the responsibilities of childrearing may encourage continued and destructive drug use in addicted mothers (Stryker 1977). Data produced by the Women's Drug Research Project show that "addicted women have fewer personal resources and skills--for coping with psychological distress (i.e., depression, anger) or with practical problem situations (e.g., financial needs, childcare)" (Reed and Moise 1979).

Since the vast majority of women who use drugs are of childbearing age (Finnegan 1979), treatment programs must be equipped to provide access to quality childcare services either within the program or through outside community resources. The lack of childcare services is repeatedly cited in drug abuse surveys as an inhibiting factor that affects not only a woman's decision to enter treatment but also her retention in a program (National Institute on Drug Abuse 1979). The need for childcare services to allow women access to treatment and rehabilitation services is just one factor justifying these services as a necessary component of drug treatment for women.

The needs of the child and the potential effect of the mother's addiction on the child's development are serious considerations for the treatment community. The children of drug-dependent mothers should receive consistent, quality care and developmental services to allow them to achieve their highest potential. The children of drug-dependent women often suffer from emotional neglect, family instability, physical neglect or abuse, lack of positive adult role models, and lack of peer relationships (Homiller 1977). In addition, family-oriented research (Harbin and Maziar 1975; Seldin 1972) has suggested that the child of the drug abuser is at risk in terms of potential abuse and neglect, poor parenting practices, and the potential for drug use.

Based on this background information, we can conclude that quality child day care services can fulfill several needs of the drug-dependent woman and her family, including the following:

- Facilitate a woman's access to treatment services;
- Assist a woman in performing her parenting role more effectively;
- Minimize the negative impact that a mother's addiction will have on her children;
- Allow her to seek necessary social and rehabilitative services;
- Enhance the development of the disadvantaged children; and
- Allow a woman to seek vocational training, education, and satisfactory employment necessary to become a self-sufficient member of society.

In this chapter, child day care services are viewed as a basic support service for the family, providing childcare and child development programs, as well as directly relating to the needs of the parents. It is seen as a service that can enhance and expand the mother's relationship with her child as well as provide a link between the family and community resources--an important step in the rehabilitative process.

Because women need assurance that their children are being well cared for while they are in treatment, this chapter will provide basic information that treatment programs can use to help clients select appropriate childcare arrangements. Further, this chapter will illustrate ways that programs with limited budgets and staff can effectively respond to this need.

The following sections include information on (1) finding quality day care services for children of drug-dependent women; (2) types of childcare; (3) creating a resource library; (4) measuring the range of services needed; (5) designating staff responsibility for coordinating childcare services; (6) identifying childcare services in the community; (7) evaluating available childcare services; and (8) helping clients choose appropriate settings.

By outlining a sequential process, this chapter will show how treatment agencies can develop a comprehensive program of childcare services without seeking additional funding or expanding the staff. These services can be incorporated into the basic treatment plan for all clients who need them. By offering family-oriented treatment that addresses the needs of both parents and children, treatment programs can provide a full range of services that can increase the potential for successful treatment outcome. Although this chapter focuses specifically on child day care services, the provision of these services is directly related to other ancillary services, including medical care, substance abuse treatment, psychological counseling, parenting practices, legal services, and vocational and educational training.

CONSIDERATIONS IN PLANNING DAY CARE

At the outset, programs should be aware of the realities of attempting to provide child day care referral and placement services. First, good day care is difficult, though not impossible, to find and is often expensive. Second, a drug-dependent woman may be the victim of social biases regarding her competence as a mother. Third, drug-dependent women may have many fears and anxieties about formal childcare arrangements.

Existing day care services range in quality from custodial situations, in which the children are only fed and protected from physical danger, to programs that enrich the children's environment in personal, social, intellectual, and physical ways that lead to accelerated development. Programs must make an exhaustive search of possible day care arrangements and evaluate the quality of care provided in each setting. Although various guidelines and questionnaires are available for assessing quality, much of the evaluation will be based on observations and "gut reactions" to the setting and the competence of the caregiver. Childcare for infants is particularly difficult to find--many centers will take only children who are toilet-trained, and many individual caregivers do not want the responsibility of infants under 6 months old. Programs should constantly be alert to creative childcare arrangements.

A random telephone survey of selected drug treatment programs in the Washington, D.C., area, New York City, and Chicago showed that programs have not experienced biases against chemically dependent women who seek child day care arrangements. In some cases, however, State and local governments responsible for assisting women seeking financial assistance for childcare did not consider drug treatment to be a necessary medical need, thereby ruling these women ineligible for public assistance. In other cases, drug-dependent women applying for public assistance for day care services were determined unfit to care for their children, and the State or local protective services agency removed the children from the home. Therefore, in many instances programs may need to intervene on behalf of their clients to argue the merits of their applications for financial assistance for day care. In certain instances, programs may need to defend a client's ability to keep her children while receiving treatment.

In addition, programs must be sensitive to the fears and anxieties clients may exhibit about seeking childcare arrangements outside the home. The counselor must be prepared to deal with the following feelings:

- The fear of being declared an unfit mother and losing her children;
- The anxiety over separation from her children;
- The fear that the day care experience may have a negative effect on her child's development;
- The fear of being replaced in her children's affection by a substitute caregiver;
- A basic distrust of bureaucratic systems;
- Anxiety over using anyone other than a family member as a substitute caregiver; and
- Fear that any alteration in her role as homemaker and full-time mother will cause her to lose her "man."

The above issues and suggested responses are addressed in depth throughout this chapter; however, they are presented here to give treatment programs an overview of the challenges they will face in providing child day care services for female clients. Simply recommending that a client find suitable childcare arrangements before entering treatment or giving her a list of childcare centers and homes to "check out" is not sufficient. Faced with the overwhelming task of finding suitable care, most women will give up after discovering waiting lists, forms, requirements, red tape, poor facilities, and so on. Therefore, treatment programs must make a commitment to help clients through each stage of the process, including identification and screening, placement, and followup. Providing childcare services will require careful planning, time, and hard work to make the community's childcare system accessible to drug-dependent women.

TYPES OF CHILD DAY CARE SERVICES

The first step in developing a comprehensive day care network is to familiarize program personnel with definitions for types of day care services and terminology used in reference to child day care services. Understanding the basic types of childcare services will help programs determine the advantages and disadvantages of day care options. Programs may want to modify the definitions provided below depending on the specific characteristics of the community and the client population they serve. Also, the State or county agency responsible for licensing day care programs may use certain definitions in categorizing types of day care services. Appendix A provides a list of the State day care licensing authorities. During initial telephone contacts with these agencies, programs should express their desire to work through State and local agencies in locating childcare arrangements for drug-dependent women seeking treatment. Programs should ask for copies of current directories of childcare centers and individual care providers, definitions of care available, and a copy of the State licensing regulations.

Although categories and definitions for child day care arrangements vary from State to State, the following broad definitions and descriptions are most frequently used. Examples of the types of programs and alternative day care arrangements in each category are also provided. Table 1 summarizes average costs, benefits, and disadvantages of each type of child day care arrangement.

What is child day care? The Federal Government's definition of day care services is the protection of children by providing part- or full-time care, supervision, and guidance when families are unable to meet these needs without assistance. Day care ranges from comprehensive programs and systems that address health, developmental, and educational needs to custodial care that simply protects the child from harm. The two general types of day care settings are home-based care and center-based care.

HOME-BASED CARE

Home-based care is commonly defined as family-like care provided by one primary caregiver in a home setting. The U.S. Department of Health and Human Services (DHHS) estimates that 40 to 50 percent of children in day care are cared for in home settings. Many mothers prefer this type of arrangement because it more closely approximates the experiences their children would have at home. Home-based day care is particularly desirable for infants and toddlers because few day care centers accept children under 2-1/2 years old or children who are not toilet trained. A survey of the Mount Pleasant community in Washington, D.C., found that mothers preferred home-like settings for infants and toddlers and day care centers for 3- to 6-year-olds (Zamoff and Lyle 1973). Also, women entering treatment for drug dependency may feel better about placing their children in a home-like setting that they can easily identify with and dealing with one primary caregiver. Likewise, a child who has never been in a formal childcare situation may adjust more readily to a home-like setting.

TABLE 1.--Types of child day care arrangements

Type of care	Average cost	Benefits	Disadvantages
Home-based care			
Extended family day care	No or minimal cost	Good backup support system Continuity of care Familiar setting	Possible conflicts between family members
Family day care home	$20-$55/week for full-day care $10-$45/week for before- and after-school care	Small group of children Opportunity for individual attention to children's needs	No license Waiting lists No transportation
Group day care home	$20-$50/week for full-day care	Interaction among children of all ages Specially equipped indoor and outdoor play areas	Little individual care No transportation
Babysitting pools	Free	Readily available source of child day care for short-term needs No waiting lists or strict requirements	Many different caregivers and different environments Inadequate for long-term childcare needs
Play groups	Free	Regular schedule of free childcare Small group of children of similar ages	Licensing requirements

TABLE 1.--Types of child day care arrangements--Continued

Type of care	Average cost	Benefits	Disadvantages
Center-based care			
Public group day care	Fees based on a sliding scale adjusted to family income	Possible comprehensive services, including health care, counseling, nutrition programs, etc. Licensed by the funding body	Waiting lists Hard-to-meet eligibility requirements Limited to certain age groups
Private group day care	$50/week	Licensed care in a structured setting Planned curriculum Large enrollments Open to children of all ages	Possible high rate of staff turnover Expensive Possible gaps in service during holidays and summer vacations

The average cost of home-based care ranges from $20 to $50 a week per child, with infant care at the higher end of the scale. A day care home may qualify for public subsidy if it serves welfare families.

Advantages of home-based care are that (1) the child is in a home-like setting that is usually near the child's home, (2) care may be provided during illness, and (3) daily activities are less structured and the hours are usually more flexible than in a day care center.

Negative aspects of this type of care are that (1) the day care home may not be licensed, which makes the quality of care difficult to assess; (2) the care the children receive may be no more than custodial; and (3) the caregiver may become ill, resulting in inconsistency and unpredictability of service.

If carefully selected and evaluated, home-based care can be a high-quality choice. Programs should ask State and local day care authorities for lists of licensed individual day care providers who have completed State- or county-sponsored training programs for childcare workers.

Types of home-based care settings include (1) extended family day care, (2) family day care home, (3) group day care home, (4) babysitting pools, and (5) play groups.

The Extended Family Day Care Arrangement. This type of arrangement uses the services of grandparents, other relatives, or a neighbor to care for children outside the home but within the extended family structure. This type of care may be a valuable support system, particularly for single-parent families. A recent NIDA study of addicted females showed that women depended heavily on their mothers for childcare support while in treatment (National Institute on Drug Abuse 1979).

Most family members will care for children at no or minimal cost. Also, in some communities, relatives may qualify for State or county subsidies for childcare in their homes. Programs should contact the local office for children or the social services department to inquire about eligibility requirements for financial assistance for childcare by family members.

The advantage of extended family childcare is that grandparents or relatives can provide warmth, security, and loving care for a child that will continue after the child moves into more structured preschool and school settings. Loss or separation of a primary caregiver may negatively affect a child's development and basic feelings of trust. Such experiences can be minimized by having the child cared for in the extended family structure.

Several considerations can help programs determine whether extended family childcare is the most appropriate arrangement for a woman and her children. For example, if there are circumstances in the woman's relationship with her parents that relate to her use of drugs; or if the grandparents use unacceptable means of discipline or criticize the woman's methods of childrearing, parents or grandparents may not be a good choice for care providers. Also, a child should not be placed in the care of a relative if the person is not able to cope physically or emotionally with small children. The treatment counselor should be aware of possible conflicts and offer guidance to the client on how to deal with such situations.

The Family Day Care Home. The family day care home is a setting that serves as many children as can be integrated into the existing physical environment and patterns of living in the home--usually no more than five or six children, including the caregiver's own preschool children. The family day care home may or may not be licensed by the county welfare department. If the home is licensed, there usually will be minimum requirements for the safety and cleanliness of the facilities and the quality of food.

This arrangement is useful for children who need close family relationships or have difficulty adjusting to larger groups. After 1 or more years of care in this type of setting, a child may adjust more easily to a structured preschool program.

The family day care home usually provides care to children of all age groups and before- and after-school care for school-age children. Costs range from $20 to $55 per week for full-day care, with a reduction of $10 per week for before- and after-school care. Financial assistance is available through State and county subsidy programs. The care provider, if qualified for such subsidies, will be familiar with the requirements for eligibility and may be able to help the mother get financial assistance.

Disadvantages of this type of care are that (1) the care provided may be no more than custodial; (2) a limited number of children are served, resulting in a low rate of turnover and long waiting lists; and (3) transportation usually is not provided.

The Group Day Care Home. The group day care home is family-like care provided in an extended or modified residence with designated indoor and outdoor, specially equipped play areas. The caregiver has hired helpers and can provide licensed care for up to 12 children (but this number varies from State to State). This type of care is suitable for children who need before- and after-school care, who do not require a great deal of individual care, and who can profit from association with other children of various ages.

Costs for care in this setting are similar to the family day care home--$20 to $55 per week. Financial assistance may also be available thorugh State and county subsidy programs.

Disadvantages of this type of childcare are as follows: (1) because of licensing requirements, the group day care home usually does not care for infants; (2) children may not receive individual care; (3) transportation usually is not provided; and (4) the group setting may not provide a continuous, central role model for the child.

Babysitting Pools. A creative childcare alternative for mothers who need limited periods of free time is the babysitting pool, a group of parents who exchange babysitting services on a regular or as-needed basis. Usually, one person acts as supervisor and maintains a list with each participant's name, address, telephone number, and the hours each participant babysits for another. When one person sits a certain number of hours, she is entitled to an equal number of hours of free babysitting.

The advantages of this type of arrangement are that (1) it is free; (2) it eliminates "red tape," waiting lists, and formal requirements; (3) it provides an opportunity for the child to interact with other children and be exposed to various caregivers; (4) it gives the mother a readily available source of short-term childcare; and (5) it is a good arrangement for infant care, which is limited in availability and often more expensive in structured childcare settings. The treatment program may want to encourage clients to form a babysitting pool, with the counselor acting as supervisor. A disadvantage of this type of care is that it meets only the short-term needs of the mother. Although it may satisfy the woman's needs for time to seek outpatient treatment, a more formal arrangement would be needed to allow her to obtain training and seek employment. Also, a child who has not been separated from his or her mother may have trouble being exposed to many different babysitters.

Play Groups. The formal play group is used by many parents as a new form of childcare for preschoolers. The play group meets on a regular basis, usually twice a week, for 2 to 3 hours a day in the parents' homes on a rotating basis. The ideal number of children for a play group is four to six who are approximately the same age. In her book How to Start Your Own Preschool Play Group, Harriett M. Watts offers ideas on how to start a play group, describes activities appropriate for different age levels, and outlines the group's basic organization.

Like the babysitting pool, the services of a play group are free; however, licensing may be required. The laws pertaining to play groups can be checked by calling the local social services agency or by calling a lawyer or the legal aid society. Often State licensing is required if more than five children meet in a house at one time on a regular basis.

CENTER-BASED CARE

Center-based child day care is a structured, preschool situation serving 25 or more children that involves a trained professional staff and classroom settings. Children are usually grouped according to age. A center that takes children of different ages can help women who have more than one child. Also, care may be offered for up to 12 hours a day. Generally, a childcare center offers coordinated and comprehensive services to both children and parents. The two types of center-based care are public group day care centers (publicly subsidized or sponsored by a voluntary organization), and private group day care centers (profit or nonprofit).

The major disadvantage of day care centers is that there are few good ones. Teachers' salaries are generally low (for example, the median 10-month salary of a day care teacher was $3,580 in 1972 [Scott 1976]), resulting in frequent staff turnover. Centers that cannot afford a professional staff may have poor educational programs. Also, centers with high staff turnover will result in inconsistent care.

Public Group Day Care. Public group day care centers are generally housed in public buildings (schools and churches), licensed by the State, and funded and supervised by State and city agencies (such as the welfare department). They often have comprehensive professional services, such as health care, counseling, and nutrition programs. In publicly funded day care centers, parents may pay fees on a sliding scale that is adjusted to income. Examples of public group day care programs are (1) Head Start, (2) extended day care programs, and (3) nursery laboratory schools.

Head Start centers are full- and half-day child development programs in the public schools for children from lower income families. The telephone numbers for Head Start centers are listed in local telephone directories under the public school listings. For example, Head Start programs in Fairfax County, Va., are located in six elementary schools, serve children ages 3 and 4, offer transportation, and serve between 14 and 30 children in each center. Because of the limited age groups served and the relatively small enrollment, Head Start centers are a limited source of childcare; however, they are worth exploring because these centers are considered models for quality care.

Extended day care centers (EDCs) provide before- and after-school care for elementary school children in the school which they attend. Extended day care is available for children enrolled in the public school system whose parents work, attend educational or training programs, or are medically unable to care for their children. For example, Fairfax County, Va., has 26 extended day care centers, each with an average enrollment of 30 to 45 children. The cost of EDC in this county-sponsored program is based on a sliding scale that ranges from $4.50 per month for a family with an income under $5,500 to $86.00 per month for a family with an income over $23,500. Activities in EDC programs may include sports, games, arts and crafts, dramatic play, construction, science and nature projects, special events, and occasional field trips. A disadvantage of this type of program is that most EDC programs follow the regular school year calendar, leaving gaps in service during summers and holidays.

Nursery laboratory schools are childcare programs established in high schools to provide experiences with children for students studying child development. Trained professionals are the primary caregivers, and students are teachers' aids. Care is usually limited to 2 or 3 days per week for children age 3 to 5 years. Maximum enrollment is usually 15 to 20 children. Because of these factors, the nursery laboratory school is a limited source of childcare. It may be an attractive type of child day care, however, for a woman who has older children in a school that has a nursery laboratory school. Contact with older siblings in the childcare setting may ease separation anxiety for both mothers and their preschool children.

Private Group Day Care. The private group day care center is a licensed, private center with trained professional staff serving groups of 12 or more children. Centers may be formed in many places: settlement houses, schools, churches, social centers, public housing units, and specially constructed facilities. They may also be adjuncts to offices or hospitals that offer day care as a fringe benefit to employees.

Private group day care is costly, averaging $50 a week per child (for a full-day program) with an additional cost of $50 per month for transportation. Private day care centers can quality for State and/or county subsidies for families in need. The directory of day care centers obtained from the State licensing authority should indicate the programs for which county or State subsidies are available.

Montessori schools are an example of private group day care. The Montessori philosophy is based on an individualized approach to learning that respects children's different interests and abilities. Children work in a "prepared" environment and are free to work with a particular material as long as they choose. The Montessori teacher serves as a resource person and a catalyst, carefully observing the children and introducing materials when they are ready for them. One advantage of Montessori schools is that the staff are trained and certified in the Montessori principles of teaching. A child who needs structure and direction, however, may not do well in the Montessori setting.

By comparison, the traditional nursery school offers a more structured planned program of activities with the goal of social and emotional growth through play. In general, nursery schools group children by age, emphasize learning through play and self-expression, and stress socialization and peer group activities.

Mother's day out (MDO) refers to half-day programs of care for very young children, including infants as young as 2 months old. The objective of the MDO program is to provide inexpensive care for preschool children during the school year, to provide the mother free time, and to provide the children an opportunity to socialize in a group environment. MDO programs are often sponsored and operated by a church or religious organization. MDOs are cooperative programs in which each mother is required to serve as a teacher's helper in the program--the number of days she serves is based on the number of days she leaves her children in the program. Because MDO is cooperative, the cost is relatively low, approximately $14 a month for each day per week attended by each child. MDO teachers are usually not professionally trained, however, so the quality of the program depends on the teacher. Also, there may be a high rate of teacher turnover due to low salaries. MDO care, however, is a viable alternative for infant and toddler care that may not be provided elsewhere.

SUMMARY

The types of childcare services and examples of different childcare arrangements discussed in this section do not exhaust the possible alternatives available to drug-dependent women. Programs should be alert to new and innovative childcare arrangements, combinations of services, and alternative funding sources. Programs can refer to table 1 in staff meetings as a basis for discussion of various childcare alternatives. Counselors might be able to add to the benefits and disadvantages of the various types of arrangements based on their personal experiences and experiences with clients. Table 1 can also be a useful tool in discussing childcare options with clients.

CREATING A RESOURCE LIBRARY

To support staff efforts in helping clients select appropriate childcare arrangements, the program should maintain a resource library that covers such topics as selecting a day care program, child development, parenting techniques, and examples of good day care. The following is a selected list of recommended books and publications.

Alternatives in Quality Child Care. Janet P. Swenson. 1972. Copies available from the Day Care and Child Development Council of America, Suite 507, 711 14th Street, N.W., Washington, D.C. 20005.

Provides a state-of-the-art review of day care in this country. Discusses the types of day care settings, factors in determining the best type of day care, learning patterns in preschool children, and parent involvement in day care.

Checking Out Child Care: A Parent Guide. Jane R. Gold and Joan M. Bergstrom. 1978. Available from the Day Care and Child Development Council.

Offers practical advice on how to select a childcare program.

Child Care and Public Policy: A Case Study. Karla Shepard Goldman and Michael Lewis. 1976. Institute for Research in

Human Development, Educational Testing Service, Princeton, N.J. 08540.

Describes the historical context of issues relating to public concern about childcare; discusses possible models for effecting childcare policy; and presents a model for uniting issues of childcare and public policy.

Child Care Provisions in Drug Abuse Treatment Programs. Report Series 43, No. 1. 1979. Available from the National Clearinghouse for Drug Abuse Information, National Institute on Drug Abuse, Rockville, Md. 20857.

A resource for State and local decisionmakers and program personnel seeking alternative treatment approaches in response to the needs of female substance abusers. Reports a survey of ways that nine States have addressed the need for childcare services to drug-dependent parents.

Day Care for School-Age Children. Elizabeth Diffendal. 1975. Available from the Day Care and Child Development Council of America.

Contains a national profile of day care services for school-age children, parents' views of school-age day care services, suggestions for planning a school-age day care program, and recommended models for school-age day care programs.

Day Care: Serving Infants. Dorothy S. Huntington, Sally Provence, and Ronald K. Parker, 1972. Available from the Office of Child Development, U.S. Department of Health and Human Services, Washington, D.C.

Reviews the developmental needs of children from birth to age 3 and outlines some of the cautions and controversies involved in infant care programs.

Formative Evaluation: Parents and Staff Working Together to Build a Responsive Environment. Lucia A. McSpadden. 1973. Available from the Day Care and Child Development Council of America.

A report of the Central City Head Start Day Care Center in Salt Lake City, Utah.

Home-Based Family Services: Report of the Georgia Outreach Project. 1975. Available from the Day Care and Child Development Council.

Describes the general design of the project; explains various aspects of staff operations; and provides case studies, parents' evaluations of their participation, and an overall evaluation of the project's success.

Parent Effectiveness Training. Dr. Thomas Gordon. 1978. Peter H. Wyden Publisher, 750 Third Avenue, New York, N.Y. 10017

Explains the P.E.T. program step by step and shows parents how they can raise happier, more responsible, and more cooperative children.

The Parenting Advisor. The Princeton Center for Infancy, Frank Caplan, General Editor. 1978. Anchor Press/Doubleday, Garden City, N.Y.

Covers all aspects of childrearing and infant research, including childbirth and early parenting; behavior patterns and routines; sensory and social powers; physical development; language acquisition; learning patterns; personality formation; and enrichment activities.

Preschool Programs for the Disadvantaged: Five Experimental Approaches to Early Childhood Education. Julian C. Stanley, ed. 1971. The Johns Hopkins University Press, Baltimore, Md.

Discusses methods of improving the educational readiness of preschoolers who come from environments that do not provide the cognitive stimulation most middle-class children receive early in life.

The following publications are available from the Office of Child Development, U.S. Department of Health and Human Services, P.O. Box 1182, Washington, D.C. 20013:

- Day Care for Other People's Children in Your Home (Pub. No. 412).
- Day Care for Your Child in a Family Home (Pub. No. 411).
- What is Good Day Care? (Pub. No. OCD 72-43).
- Day Care Services: Why? What? Where? When? How? (Pub. No. 420).
- Bibliography of Home-Based Child Development Program Resources (Pub. No. OHD 74-1067).

In addition, the Day Care and Child Development Council of America, Suite 507, 711 14th Street, N.W., Washington, D.C. 20005, serves as an advocacy office for day care and children's rights and is also a major distributor for day care information. Appendix B lists materials available from the council.

MEASURING THE SCOPE OF SERVICES NEEDED

The first step in developing a childcare referral network is to conduct a needs assessment to determine the range and type of childcare services needed by female clients in treatment. The general population of women needing child day care services should include women in treatment as well as women who are not entering treatment because of childcare constraints. Data for the needs assessment survey can be obtained from several sources: (1) client case records, (2) interviews with clients currently in treatment, (3) interviews with persons in the community responsible for licensing child day care programs, and (4) information from social services agencies and current clients on the unmet needs of drug-dependent women in the general population.

Assuming the program is part of the Client Oriented Data Acquisition Process (CODAP) system, client case records will, at minimum, contain the following relevant information on the female clients in the program: age, race, marital status, educational level, employment status, and socioeconomic status. These basic data will show (1) the number of women of childbearing age, (2) the number of women currently employed, and (3) the number of women who currently receive or are eligible for public assistance. Many programs use an admission form in addition to CODAP; some of these forms contain family, lifestyle, and social environmental data (Sheridan 1980).

It is doubtful, however, that case records will contain information on maternal caregiving patterns, problems, and needs. You will have to obtain this information through client interviews. The following is a sample list of questions that might be asked. Programs can modify this questionnaire as necessary.

1. What is the number and age of children in the family?
2. How many adults are living in the home who help with childcare?
3. What is the family's cultural and ethnic background?
4. Is the family bilingual?
5. What is the family's religious preference?
6. Is the mother currently employed or seeking employment?
7. What is the present child day care arrangement?
8. Will the mother need a different childcare arrangement to obtain job training, education, or employment?
9. Are grandparents or relatives nearby who can provide daily or emergency childcare services?

10. Does the family currently receive any type of public assistance?

Counselors should complete this questionnaire for the women in their current caseload. The counselors will be able to answer most of the items from their knowledge of the clients. Additional information can be added by the counselor during regular treatment sessions, where the purpose of the questions is explained and the program's plan to explore offering assistance in obtaining childcare services is described.

The third source of data is the State or county social services department responsible for childcare services, which may have survey data on the child day care needs of the community or district that the treatment program serves. This source also may have information on the number of single-parent families, the percentage of women in the community currently in the workforce, the number of families receiving public assistance, and current waiting lists for available child day care services and average length of time for placement. This information can provide an overview of the availability of childcare services in the community. For example, there may be long waiting lists for childcare centers, resulting in delays of 6 months to 1 year for placement. Using this information during their planning and implementation stage, programs may want to direct efforts to alternative childcare arrangements, such as babysitting pools, play groups, extended family care, etc.--forms of day care that are more readily available and can be used while a woman is waiting to place her child in a childcare center or for approval of public assistance for day care.

As the final step in the overall assessment of need, programs should try to determine the number of women who might enter treatment if childcare services were made available. Although formal surveys to determine the unmet need for services can involve costly data collection procedures and complex statistical analyses, a simple method of obtaining information is an informal survey of both male and female clients currently in treatment that asks if they know women in the community who might enter treatment if childcare services were available. Also, social services agencies may have information on the needs of drug-dependent women who are not in treatment.

The data obtained during the needs assessment can be summarized into a management report to be used during the planning and development of the child day care referral network. The report should address the following areas:

- The percentage of children in each age group of child day care classification:

    1. Infants: birth to 1 year.
    2. Toddlers: 1 to 2-1/2 years.

3. Preschoolers: 2-1/2 to 5 years.
4. Before- and after-school care: 6 to 11 years.

- The percentage of bilingual families in the treatment population and in the general population in the community served by the program.

- The types of cultural and ethnic and religious backgrounds represented.

- The type of childcare arrangements currently used by women in the program.

- The percentage of mothers who have backup childcare arrangements for emergencies.

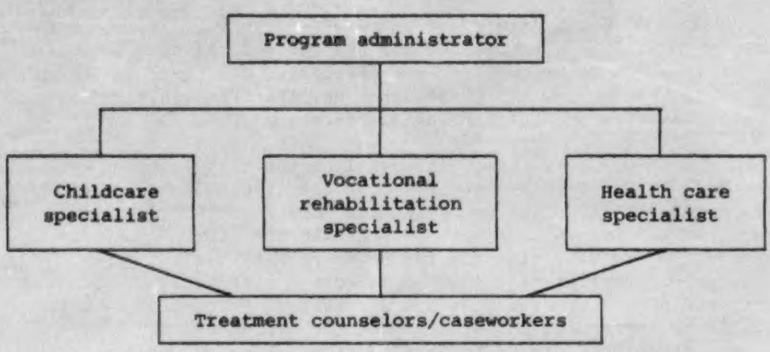
- The percentage of families in the program and in the community served by the program who receive some type of public assistance.

- The percentage of women enrolled in the program, currently using childcare, whose needs for childcare may change in the near future.

- An estimate of the number of women who might enter treatment if childcare services were available.

STAFFING CONSIDERATIONS

Depending on the size and structure of the program, the director or administrator should assign various staff responsibilities for development and implementation. If other specialized services (e.g., vocational counseling, health care, etc.) are centralized, a staff position could be created for childcare coordination and referral services. A counselor may assume this role. This person, designated as the childcare specialist, would be supervised by the program administrator and work directly with individual counselors to coordinate childcare services for individual clients. The staffing plan for this organizational structure would be as follows:


Program administrator
Childcare specialist
Vocational rehabilitation specialist
Health care specialist
Treatment counselors/caseworkers

The childcare specialist should possess skills in parenting training; an educational background or formal training in child development; prior experience in a day care program (as either an administrator, a teacher, a caregiver, a teacher's aid, or a volunteer); and prior experience with the child welfare system. Although it may not be a written requirement, program administrators may want to give special consideration to selecting a woman who has children in day care, thereby providing the added dimension of direct experience with the day care facilities in the community and a sensitivity to the issues women face. Applicants for the childcare specialist position should be recruited from licensed childcare facilities, State or local social services agencies, and local school systems. The responsibilities of this position would include the following:

- Development and implementation of the childcare services referral network;
- Development of in-service training programs for counselors on various aspects of childcare services relating to both the mother and the child;
- Coordination with State and local childcare resource agencies;
- Creation of a reference library of current literature on day care services, child development, parenting, social work, health services, etc.;
- Ongoing liaison with and training of child welfare and day care staff;
- Supervision of childcare placements and troubleshooting;
- Coordination with counselors regarding the childcare needs of their clients; and

- Direct work with female clients (e.g., accompanying them on visits to day care homes and centers; helping them in ongoing relationships with caretakers and their children; providing parenting training; helping them qualify for financial assistance for day care).

Although the childcare specialist will be the central resource for access to child day care services, the treatment counselors will need to be aware of and sensitive to childcare issues to meet the needs of their clients. For example, a client may prefer working directly with the counselor rather than with the childcare specialist in exploring childcare alternatives. In this case, the counselor would use the services of the childcare specialist as a resource to help to meet the client's needs. Counselors, therefore, should be knowledgeable about the available child day care services in the community.

Programs should contact the State or local welfare department, day care licensing authority, office for children, and similar agencies for information on training programs for childcare providers. For example, in Virginia, the Office for Children offers training and professional assistance for child center staff and family day care providers, as well as assistance in choosing the most appropriate type of care.

DEVELOPING THE CHILDCARE SERVICES REFERRAL NETWORK

IDENTIFYING THE SOURCES OF CHILDCARE

The treatment program should first develop a comprehensive list of potential resources for child day care information, including the following: (1) Federal agencies that provide funding and assistance to States for childcare programs, (2) State agencies and umbrella organizations that have responsibility for funding or licensing child day care centers and homes, (3) community organizations that may sponsor or coordinate child day care programs, and (4) childcare centers and homes. Figure 1 illustrates suggested resources for information about childcare services. The next section discusses information available at each point of contact, including names, addresses, and phone numbers of recommended contacts and suggestions on areas of inquiry.

The Federal Government. The first critical level of inquiry about child day care services is the Federal Government. The Federal Government currently spends $2 billion a year on day care for 2.5 million children. Federal programs for child day care include the title XX day care programs and the Head Start Program day care component.

The following is a list of agencies that can provide relevant information on Federal day care programs:

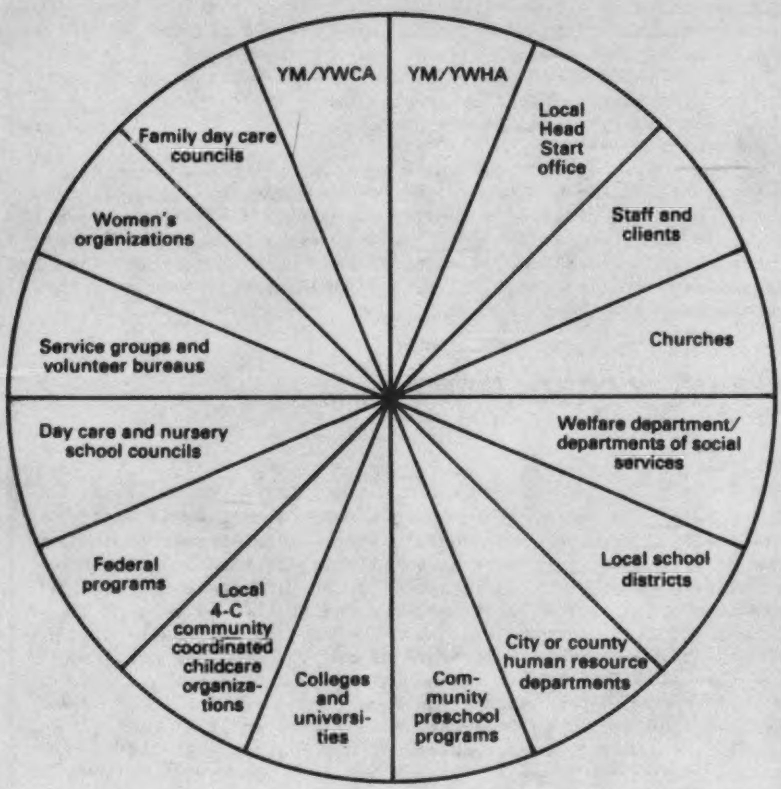

YM/YWCA
YM/YWHA
Local Head Start office
Staff and clients
Churches
Welfare department/ departments of social services
Local school districts
City or county human resource departments
Community preschool programs
Colleges and universities
Local 4-C community coordinated childcare organizations
Federal programs
Day care and nursery school councils
Service groups and volunteer bureaus
Women's organizations
Family day care councils

FIGURE 1. Potential resources for day care information

Mr. Frank Ferro
Children's Bureau
U.S. Department of Health and Human Services
400 6th Street, S.W.
Washington, D.C. 20024
(202) 755-7724

Administers research, program development, and operation of day care services in Head Start, child abuse prevention, etc.

Administrator
Office of Family Assistance
U.S. Department of Health and Human Services
122 C Street, N.W.
Washington, D.C. 20001
(202) 245-2041

Provides direction and technical assistance in the administration of aid to families with dependent children, emergency welfare, and energy assistance to low income groups. Coordinates the Child Welfare Service and the Work Incentive Program (WIN) and other work training programs.

U.S. Department of Labor
Manpower Administration
14th St. & Constitution Ave., N.W.
Washington, D.C. 20210
(202) 393-2420

The job training program, including CETA (Comprehensive Employment and Training Act), finances work training and work projects, including childcare. The Women's Bureau ([202] 523-6611) is also concerned with problems of women and childcare.

Community Services Administration
1200 19th Street, N.W.
Washington, D.C. 20506
(202) 254-5840

Administers antipoverty projects and oversees Head Start Program.

Contacts to Federal agencies should be made in writing or by telephone. Programs should keep a written record of each contact, noting at minimum the following information:

- Name of contact person;

- Agency name;

- Address;
- Telephone number; and
- Responses to questions:
  1. What programs related to child day care does your agency administer or oversee?
  2. What funding does your agency provide to States for child day care?
  3. What are the guidelines/requirements for funding?
  4. What training or technical assistance is available?
  5. What literature is available?
  6. What other persons/agencies should I contact regarding federally sponsored day care programs?

Title XX of the Social Security Act, the largest federally funded child day care program, makes available formula grants to States for the operation on the State level of childcare and other social service programs, including Child Welfare Services, to help prevent the neglect and abuse of children; and the Work Incentive Program (WIN), to provide childcare and other services to those in work training programs. The title XX day care program at the Federal level is under the control of the Community Services Administration of the U.S. Department of Health and Human Services (DHHS). The Office of Child Development (OCD) in DHHS is responsible for guaranteeing the quality of title XX day care. The title XX program is designed to serve children of the economically disadvantaged. Although supported through Federal funds, title XX is an optional State-operated program. Most States, however, do have title XX day care. Some exceptions are Alaska and Minnesota, where child day care is supported totally through State funds (these States have in effect "bought out" the title XX day care program). Because title XX day care is operated at the State level, the eligibility requirements vary. Some States (e.g., Kansas) limit title XX day care to families who are receiving Aid to Families with Dependent Children (AFDC).

In Virginia, day care centers and individual day care providers are approved by the State to receive title XX eligible children. The only mandated target population for title XX day care are families who need day care for purposes of employment or education or training leading to employment. Virginia, in addition to the mandated employment-related eligibility criteria, has optional conditions whereby the State can determine a family eligible for day care. Such optional cases include "for the purpose of protection, temporary absence or illness of the parent/caretaker; or for meeting the special developmental needs of the child where the service and the populations to be served are included in a geographic area's Title XX services plan." Based on these criteria, the availability of childcare through title XX for mothers participating in a drug abuse treatment program would be optional for the local agency, with each case evaluated individually.

The Head Start day care component is under the jurisdiction of the Office of Child Development in DHHS. This program also serves children of the economically disadvantaged. The Head Start day care programs have educational and health components designed to meet the needs of the children they serve.

State Resources. Although States must meet federally mandated requirements and guidelines, each operates federally subsidized day care programs differently. Programs should contact by telephone their State's title XX coordinator (listed under the State department of social services or the welfare department in the telephone directory) and request the following, if available:

- A State-published citizen's handbook containing information about services offered by government agencies, names of agencies, and telephone numbers;
- A copy of the State guidelines and eligibility criteria for title XX day care;
- The name of the person and agency responsible for title XX day care in the program's community; and
- An interpretation of the title XX eligibility criteria as they apply to mothers seeking treatment in drug abuse treatment programs.

Licensing for day care also is regulated at the State level. In most States, day care licensing is the responsibility of the State department of public welfare. In Arizona, the District of Columbia, Maryland, Massachusetts, and New Mexico, day care standards and licensing are supervised by the State health department. In New Jersey, licensing is under the control of the Department of Institutions and Agencies. In Louisiana, Mississippi, and North Carolina, licensing is a voluntary decision. Most States maintain lists of approved day care centers and individual providers. Appendix A provides a list of State agencies responsible for licensing day care facilities.

Programs should contact the State licensing agency by telephone or in writing and ask for the following:

- A current listing of approved day care centers and day care homes;
- Relevant contacts in the program's community for inquiries about available childcare services; and

- Training or technical assistance services offered by the State.

To assure future cooperation and to begin to establish working relationships with State and local day care governing bodies, program staff should explain that the program wants to meet the childcare needs of drug-dependent women so that those women can receive treatment and rehabilitative services. Because many decisions regarding eligibility for financial assistance for mothers needing drug treatment services may be borderline, programs should secure support for their efforts from State and local officials. Representatives of State and county agencies are often available to discuss the services they offer and to acquaint the treatment program staff with licensing requirements, eligibility requirements, and referral procedures.

Umbrella Organizations. Various agencies and organizations operate networks of family day care homes. In some instances, an agency has been given authority by the State to register or license homes. Women interested in providing family day care may apply to the agency to receive training supervision, play materials, substitute caregivers for vacations and emergencies, sample forms for medical releases, admission attendance and other recordkeeping, help in drawing up contracts, and opportunities to gather on a regular basis with other providers to discuss problems and share ideas. Organizations that may have information about an umbrella agency in your community include the local community coordinated childcare council, community colleges and universities, civic groups, and local family day care councils.

Resources in the Community. From contacts with the various resources discussed earlier, programs should have a list of recommended agencies and persons in the community to contact for additional information. Each contact should be made in person if possible. At minimum, during the initial contact, program staff should obtain information on the following:

- Day care services/centers/homes in the community that might be accessible for female clients in drug treatment in terms of financing, location, and quality of services offered; and

- Services, technical assistance, or training that they may offer to facilitate the identification and placement process.

In addition to resource persons and agencies recommended for contact, the following additional contacts should be made for information about childcare services:

- The local department of welfare, division of youth and family services, may offer lists of local day care programs.

- Local chapters of the National Organization for Women (NOW) and other women's organizations frequently have childcare task forces and information services. They might also help the program survey their membership about childcare arrangements used.

- Teachers and administrators in local elementary schools and preschool programs can help identify day care programs in your area.

- The local community coordinated childcare council (4-C).

- YM/YWCA and YM/YWHA and Christian or Jewish community centers are sources of family services, including parenting courses, prenatal programs, after-school childcare, full-day or part-time nursery and childcare programs, and courses on P.E.T. and single parenthood.

- Community organizations and councils.

- Local colleges and universities may have directories of childcare programs and homes and may offer placement assistance.

- Day care and nursery school councils.

- The local Head Start office will have information about the number and location of Head Start day care programs operated in public schools.

- Staff, clients, friends, and volunteers in the treatment program who currently have their children in a day care setting are a valuable resource.

- The Yellow Pages of the telephone directory will have listings of private day care centers and nursery schools.

- Local newspapers will often contain advertising for day care programs and providers who have available space.

The information obtained through contacts with the agencies and organizations listed should be categorized into two groups: home-based care and center-based care. The following basic information should be recorded for each childcare setting:

- Length of time in operation;
- Type and number of staff;
- Whether the program is licensed;
- Whether toilet training is a requirement;
- Other eligibility requirements;
- Number and ages of children served;
- Number of meals provided;
- Services provided;

- Cost requirements; and
- Transportation services.

This information, although sufficient for the initial search, does not address determining the quality of services provided. Criteria for evaluating the quality of childcare programs and selecting a program to meet the needs of the mother and her children will be discussed later in this chapter.

KEEPING INFORMATION CURRENT

If the childcare referral system is to be effective, the treatment program should develop a procedure for updating its resource files at least annually (probably much more often) to determine the following:

- What are the available vacancies?

- Is the childcare center or home still operating?

- What new settings have been established? (This information could be determined from new listings of licensed facilities available from the State or county licensing authority or through monitoring newspapers and classified ads.)

- What has been the experience of mothers in treatment who have children in various childcare settings?

EVALUATING CHILD DAY CARE PROGRAMS

Ideally, knowledge about the quality of all childcare settings in the community should be gathered. The initial evaluation can be limited to programs that might be used based on availability of financial assistance and other factors. Information can be obtained from the licensing authority; however, if possible, the treatment program should contact each center and day care home either by phone or through onsite visits to determine the range of services and quality of care provided. The treatment program should obtain and be familiar with Federal and State minimum requirements, a copy of which should have been requested during prior contacts with State agency officials. Most States require a certain minimum space indoors and outdoors, depending on the number of children served. In addition, health, sleeping facilities, diapering and toilet facilities, food preparation and feeding, and the staff/child ratio are likely to be under State regulation.

The following criteria for measuring the quality of child day care programs will give treatment programs an idea of what to look for in evaluating childcare settings. A checklist evaluation form (figure 2) is provided at the end of this section for rating qualities of service.

THE CAREGIVER

A responsive, competent caregiver can give a young child valuable experience in learning to adjust to the expectations of someone other than the mother; however, a poor caregiver can inflict lasting emotional damage, as has been documented in infant research studies (Caplan 1978). A competent caregiver, therefore, should be warm and responsive with children, encourage intellectual growth and development; respect the child's individual needs, be able to cope with the demands of caring for children, and be consistent and fair in disciplining them (Gold and Bergstrom 1978). The competence of caregivers can be measured by observing how they interact with the children under their care. For example, does the caregiver talk to the baby while changing a diaper, hold the infant while feeding, and pay attention to each child's temperament and developmental needs? In relating to older children, does the caregiver give individual attention to the children as needed, encouraging them to find their own answers and create their own pictures and dramatic situations? Do the children trust the caregiver and look to him or her for guidance?

STAFF/CHILD RATIO

The staff/child ratio directly affects the quality of childcare. As the number of children in a setting increases, so does the potential for aggressive behavior and distracting situations. Most childcare settings follow the Federal Interagency Day Care Requirements for staff/child ratio.

- Center-based care:
    1. For 3- to 4-year-olds: one adult for every five children.
    2. For 4- to 6-year-olds: one adult for every seven children.
    3. For 6- to 14-year-olds: one adult for every ten children.
- Family day care programs:
    1. For up to 2-year-olds: one adult for every two children.
    2. For 2- to 6-year-olds: one adult for every five children (assuming those five include the caregiver's own children and involve no more than two children under age 2).

DISCIPLINE AND BEHAVIOR

Indicators of discipline and behavior are measured by the perceptions and observations of the evaluator. The following are suggestions on what to look for.

- Do the caregivers have a loving and patient attitude with the children, or do they resort to yelling and threats?
- How is toilet training handled? Are the children punished or reprimanded for accidents?
- What is the basic method of discipline? Do you feel comfortable with these methods?
- How does the caregiver handle disputes among the children?
- Is the caregiver's interaction with the children heavily sprinkled with dos and don'ts?
- Does the caregiver have different expectations and treatment for girls and boys?
- Does the caregiver reprimand the girls and boys differently?

ATMOSPHERE

Observing how children work and play together can be the best indicator of the quality of the program and the competence of the caregiver. Measures of the program's atmosphere include the following:

- Do the caregivers and children enjoy themselves?
- Are parents welcomed to visit at any time, without advance notice?
- Do the children seem happy?
- Do the children trust the teachers and turn to them for help?
- Are the children relaxed?
- Do the children appear to be comfortable with one another, or are there constant fights and disturbances?

PHYSICAL ENVIRONMENT

The physical facilities for day care programs are usually regulated by State or county licensing authorities. During the onsite visit, the treatment program evaluator should not be presented as a licensing official, but rather as an observer:

- Does the physical environment have sufficient space for play, both indoors and outdoors?
- Is the facility or home free from accidental hazards?
- Are the bathroom facilities clean?
- Does the program have basic equipment, materials, and toys neatly arranged and within easy reach of the children?
- Are the areas for naps clean and comfortable?

SERVICES PROVIDED

The range of services will vary with the size and funding of the program. The following is a discussion of basic services.

Daily Program of Activities. Does the center have a detailed schedule of activities for the children, or is the program flexible, leaving planning of activities up to the caregiver each day? Are opportunities provided for active play periods alternated with quiet times? Are materials (paint, paste, and paper) and time provided for creative play? Is there space and equipment for dramatic play to allow children to act various roles and express feelings and experiences? How many hours of television do the children watch during the day? (This is a particular consideration in home-based care.) In programs that involve minority children, are bilingual and bicultural activities part of the daily program?

Parental Participation. For drug-dependent women who may feel threatened by the possible loss of control and/or loss of their child, a program that encourages parental participation can relieve much of this anxiety. Although many mothers, especially single parents, have many demands on their time, the childcare program can relate to and involve parents in many ways. The program should be flexible enough so that caregivers are available at times convenient to the mother to discuss the child's progress. Other forms of parent participation include the use of parents as volunteers, parenting skills programs, and open house functions where parents can observe their children and talk to the teacher or caregiver.

Health Services. Health care and health education are extremely important aspects of a good day care program. In most States, an enrollment physical exam and immunizations are required by licensing regulations before a child can enter day care. Such services to children from low-income families are often available through public health clinics. Some programs employ various health professionals either full time or part time, including pediatricians, nurses, social workers, psychologists, psychiatrists, speech therapists, nutritionists, and dentists. If health services are not provided, the program may coordinate services with the State health department or the community health center. Areas to be checked during the onsite visit include the following:

- Does the program have written health guidelines for children enrolled in the program?
- Does the program have written guidelines for the management of medical emergencies?
- Does the program have a policy on the enrollment of handicapped children?
- What are the health requirements for entry? What medical examinations and immunizations are required before entry? What forms need to be completed?

Nutrition Services. Because many children of working mothers are in day care approximately 10 hours a day, a sound nutritional component is essential. Such a program can help children establish good early eating habits. Programs might schedule a visit during lunch hour to evaluate the type of food served. This evaluation should also include types of snacks served and their frequency. The evaluator should notice if the children participate in food preparation. Comprehensive nutrition services might include a full-time nutritionist, consultation services to mothers, establishment of standards for the quality and cost of feeding programs, and training for families to help them meet their children's basic nutritional needs.

EVALUATION INSTRUMENT

The following rating sheet for evaluation of day care settings is taken from the book *New Life Options: The Working Woman's Resource Book* (Loring and Otto 1976). This instrument was developed to help parents know what to look for in selecting a childcare setting. The rating sheet uses forced-choice categories: Each aspect of childcare is rated "acceptable" or "unacceptable." This approach is offered because individual choices concerning day care are usually based on acceptability rather than on a complex system of scoring.

FACTORS INFLUENCING CHILDCARE DECISIONS

The choice of a child day care arrangement depends on several factors: the mother's feelings about what is best for her children, the treatment program's assessment of the family situation, and an assessment of community childcare resources.

Once the child day care referral network has been established, treatment staff can begin to help clients and potential clients select appropriate childcare settings. This service can be provided by either the childcare specialist or individual counselors, depending on the organizational structure of the program. Because the need for childcare services may affect a woman's ability to enter treatment, counseling for selection of child day care services should become part of the intake process. The following steps are recommended for coordinating child day care resources with individual family needs.

STEP ONE: HELP THE CLIENT HAVE A POSITIVE ATTITUDE ABOUT CHILD DAY CARE

Most women have feelings of anxiety about leaving their child in a childcare situation, especially for long periods of time. Women with a substance abuse problem may also have feelings of inadequacy as parents. The mother may feel sad or guilty about leaving her child and jealous that another caregiver may supplant her in her child's affections. During the intake process, the treatment counselor should be aware of such feelings and assure the woman that quality day care arrangements can contribute greatly to strengthening family life in general and the mother/child relationship in particular. Indications of a woman's internal conflicts about childcare might include feelings of social pressure to be at home with her children; inability to deal with a husband's uncooperative attitude; or guilt feelings about having to explain to small children why they have to go into a day care setting. The solution to each of these problems must be dealt with on an individual basis; however, if a woman has difficulty in opening up during individual counseling sessions, it might be helpful to have her participate in a group session with other women in the program who have children in day care settings. The goal should be for the woman to view the day care experience in a positive light, as an experience that supplements, not replaces, the care and affection a child receives at home.

STEP TWO: ASSESS THE NEEDS OF THE MOTHER AND THE NEEDS OF THE CHILD

An initial consideration in determining an appropriate childcare arrangement is the client's treatment plan and long-term goals regarding the basic treatment regimen, job training, educational opportunities, and employment goals. Care should be taken to select a childcare setting that will meet the mother's present and future needs. At minimum, any child day care setting must meet the basic needs regarding (1) the hours of the day and days of the week care is needed, (2) the age of the child or children to be served, (3) transportation requirements, and (4) financial arrangements. After these initial requirements have been met, the social, emotional, and physical health needs of the mother and the child can be addressed.

The Mother's Needs. In assessing the mother's needs and preferences, the counselor should make the following inquiries:

- What is the mother's preference regarding a home-based or center-based program? Does the mother want her child in a home environment until school age, or does she feel a structured school-based environment is best? A survey conducted in 1970 (Westinghouse Learning Corporation and Westat Research, Inc. 1971) found that mothers indicated the highest degree of satisfaction with day care centers that met Federal or State guidelines.

- What is the mother's preference for the type of caregiver? Is it important that the woman have children of her own? Should the caregiver have set ideas and practices of childcare, or should she be more flexible and willing to follow the desires of the parent in such areas as food, toilet training practices, and so on. It is important that such issues are raised at the outset and discussed with prospective caregivers.

- Does the mother place any importance on fostering relationships with caregivers or children from different ethnic, racial, or religious backgrounds? The program should probably encourage such arrangements to provide continuity in the caretaking styles between the child's own home and the childcare setting.

- Does the mother find the child difficult to manage for any reason? Are these problems associated with normal stages of development (e.g., temper tantrums, negativism, attachment to security items, aggressiveness), or are they symptoms that might indicate extreme anxiety, fear, etc. (e.g., muscle tics, head banging).

- How does the mother feel her drug dependency problem has affected her child?

The Child's Needs. The needs of the child can be determined from home visits, discussions with the mother, and the counselor's observations of the parent/child relationship. During the initial step of discussing and identifying various childcare arrangements, the counselor might encourage the woman to bring her children with her on scheduled visits. Areas of consideration in determining the needs of the child include the following:

- What are the health needs of the child? Does the child have any physical handicaps? Has the child received the necessary immunizations? Does the child appear to be under- or overweight? Does the child have any medical problems that might restrict her or his activities in any way? If the child has severe emotional or physical handicaps, a specially designed day care program may be needed.

- Is the child an only child? Does the child have opportunities to play with other children on a regular basis? If the child has had little opportunity for interaction with other children on a regular basis, a childcare home with more flexibility and a small group of children may initially be more suitable than center-based care. It would also be beneficial in this case if all of the children in the caregiver's home were approximately the same age. A young child may have difficulty keeping up with older children.

- Has the child suffered physical or emotional abuse or neglect? Physical abuse or neglect can be determined by the general appearance of the child (e.g., signs of bruises, extreme weight loss, etc.). Emotional problems can be indicated by signs of listlessness, stuttering, and so on.

- In the immediate neighborhood, does the child have an opportunity to play with others of his or her own age? Of different ages? Again, these factors will affect the age and number of children in the childcare setting selected.

- Consider the child's personality and tendencies. How much individual attention does the child need? This will influence the caregiver/child ratio.

- What are the child's individual needs as perceived by the parent?

- Observe the child for emotional tendencies during discussions with the mother. If the child is contrary, easily frustrated, or easily frightened, the adult attitude toward this behavior will determine how that child is going to react in a group situation. This in turn will determine the type of group situation chosen. In many instances, a child may act differently when with the mother than when with other adults. If the mother agrees, the counselor may spend some time alone with the child.

- Observe the child for signs of excessive fear or anxiety. Anxiety can result from overly severe punishment and restrictions, inconsistency in the way the child is treated, and wide mood swings in the way the mother reacts to the child. Studies have found that anxious children do much better in structured and directed learning settings than in loose ones (Swenson 1972).

- Note the stage the child is at in toilet training. What are the mother's practices regarding toilet training? Because toilet training may be a criterion for enrollment in many day care centers, it should be discussed with the mother before selecting day care centers or homes for visits. If the child is not toilet trained, however, the mother should not push the child to train just to meet the enrollment requirement. The pressure to toilet train, coupled with the adjustment to the day care arrangement, may produce serious negative reactions in the child.

STEP THREE: ACQUAINT THE CLIENT WITH THE TYPES OF CHILD DAY CARE SERVICES AVAILABLE

The counselor should provide information about available childcare arrangements, discuss the positive and negative aspects of various arrangements, and answer the client's questions about particular settings. The woman should have a clear understanding of the differences among these arrangements. A list of centers and day care homes that appear to meet the needs of the mother and her children should be prepared by the counselor or the childcare specialist.

STEP FOUR: ARRANGE FOR THE CLIENT TO VISIT VARIOUS DAY CARE PROGRAMS

The counselor should encourage and arrange client visits to several child day care settings so that she can observe classes in session and talk to the teachers or caregivers. The woman may request that the counselor or childcare specialist accompany her on such visits and point out the advantages and disadvantages of the different settings. The checklist in figure 2 should be used as an assessment tool. Add to this list any additional concerns that are not covered on the form. The child should be included in these visits if possible so that the mother can observe how the caregiver reacts to her child and how the child reacts to the situation. During the first visit, the counselor and the mother should drop by unannounced, either in the morning when the children are just arriving, or before naptime or lunchtime, when most children are at their worst behavior. If the atmosphere is reasonably calm during these periods, it is a good indication of a well-managed program or home. During the interviews with the center administrator or individual caregiver, the mother should explain her specific needs, describe what she is looking for in a childcare setting, and voice her concerns about her child's adjustment to the setting. In addition to meeting with administrators, teachers, or caregivers and touring the program, the mother should ask for the names and telephone numbers of several parents whose children attend the center or home. Another mother's positive report about a program may help ease a mother's fears and anxieties.

STEP FIVE: COMPLETE THE SELECTION AND PLACEMENT PROCESS

After the mother has chosen a childcare setting, the counselor or childcare specialist can assist in the placement process by helping the mother complete application forms, meet health requirements (most States require a physical checkup for the child and a physical checkup and TB test for the mother if she is to participate in the program), apply for financing through social services agencies, make arrangements for transportation, attend orientation sessions, and obtain the materials the child needs to bring. Finally, if there is a waiting list at the preferred setting, or if there will be delays in getting approval for financial assistance, the counselor or childcare specialist can help the mother find temporary care settings, such as babysitting pools or play groups.

STEP SIX: PROVIDE FOLLOWUP ASSISTANCE

When the child is enrolled, the counselor should work with the mother to help her and her child make the necessary emotional adjustments. Before she takes her child on the first day, the counselor should prepare her for the possibility that the child may resist being left and may cry and cling to her. Assure her that this is a normal reaction. In fact, most children stop crying shortly after the mother has left. The counselor should encourage the woman to have frequent discussions with the teacher or caregiver about how her child is doing. Also, the mother should talk to the child about the program. If after a reasonable time has passed (usually a month) and the child is constantly clinging and whining and won't discuss the program, the teacher or caregiver, or the other children, it may be necessary to make other arrangements. For example, if the child is in a structured environment, a change to more individual care may be advisable for a 1-year period. Also, as part of the followup process, the counselor should encourage the woman to participate in activities at the center, become acquainted with other mothers whose children are enrolled in the program/home, and act as a resource for new clients entering treatment who need access to the child day care system.

APPENDIX A
STATE DAY CARE LICENSING AUTHORITIES

Supervisor of Child Caring Institutions and Agencies
64 N. Union Street
Montgomery, AL 36104

Division of Public Welfare
Department of Health and Welfare
Pouch H
Juneau, AK 99801

Child Day Care Health Consultant
Arizona State Dept. of Health
1624 W. Adams Street
Phoenix, AZ 85007

Day Care Specialist
Dept. of Public Welfare
P.O. Box 1437
Little Rock, AR 72202

Day Care Consultant
Adoptions and Foster Care Bureau
Dept. of Social Welfare
744 P Street
Sacramento, CA 95814

Licensing and Standards
Division of Welfare
1575 Sherman Street
Denver, CO 80230

Day Care Licensing
Connecticut State Health Dept.
79 Elm Street
Hartford, CT 06106

Chief, Day Care Licensing
Bureau of Child Development
P.O. Box 309
Wilmington, DE 19899

Child Care Specialist
801 N. Capitol Street, Rm. 501
Washington, DC 20001

Supervisor, Day Care Unit
Division of Family Services
5920 Expressway
P.O. Box 2050
Jacksonville, FL 32203

Chief, Day Care Licensing
State Dept. of Family and Children Services
613 Trinity-Washington Building
Atlanta, GA 30334

State Dept. of Social Services
Day Care Licensing
P.O. Box 339
Honolulu, HI 96809

Day Care Licensing
Bureau of Family & Children's Services
P.O. Box 1189
Boise, ID 83701

Day Care Licensing
Dept. of Children and Family Services
Springfield, IL 62706

Day Care Supervisor
Dept. of Public Welfare
100 N. Senate Avenue, Rm. 701
Indianapolis, IN 46204

Day Care Supervisor
Dept. of Social Services
Lucas State Office Building
Des Moines, IA 50319

Day Care Supervisor
Division of Child Welfare
State Dept. of Social Welfare
State Office Building
Topeka, KS 66612

Dept. of Child Welfare--Day Care
Chief, Office of Special Services
403 Wapping Street
Frankfort, KY 40601

Dept. of Public Welfare
Director, Child Welfare and Day Care
P.O. Box 44065
Baton Rouge, LA 70804

Licensing Supervisor--Day Care
Dept. of Health and Welfare
State House
Augusta, ME 04330

Child Day Care Center Coordinator
State Dept. of Health
301 W. Preston Street
Baltimore, MD 21201

Group Day Care Licensing
Dept. of Public Health
88 Broad Street
Boston, MA 02110

Day Care Licensing
Dept. of Public Welfare
600 Washington Street
Boston, MA 02111

Day Care Supervisor
Bureau of Family and Children's Services
300 S. Capitol
Lansing, MI 48926

Day Care Supervisor
Child Welfare Division
Centennial Building
St. Paul, MN 55101

Day Care Supervisor
Division of Family and Children's Services
P.O. Box 4321, Fondren Station
Jackson, MS 39216

Day Care Unit
Bureau of Family and Children's Services
State Dept. of Public Health and Welfare
Broadway State Office Building
Jefferson City, MO 65101

Licensing Specialist
Dept. of Public Welfare
P.O. Box 1723
Helena, MT 59601

Day Care Welfare Consultant
Dept. of Public Welfare
1526 K St., Fourth Floor
Lincoln, NB 68508

Licensing Specialist
Welfare Division--Day Care
201 S. Fall Street
Carson City, NV 89701

Day Care Licensing
Division of Welfare
Concord, NH 03301

Day Care Consultant
N.J. Dept. of Institutions and Agencies
111 Franklin Street
Trenton, NJ 08611

Licensing Section
Health and Social Services Dept.
P.O. Box 2348
Santa Fe, NM 87501

Day Care Consultant
N.Y. State Dept. of Social Services
1450 Western Avenue
Albany, NY 12203

Day Care Consultant
Dept. of Social Services
Raleigh, NC 27602

Director of Social Services
Day Care
Capitol Building
Bismarck, ND 58501

Chief of Day Care Services
Division of Welfare Services
Oak & Ninth Streets
Columbus, OH 43215

Children's Day Care Services
State Dept. of Public Welfare
P.O. Box 25352
Oklahoma City, OK 73125

Public Welfare Day Care Unit
Public Service Building
Salem, OR 97310

Licensing Supervisor
Office of Family Services
Health and Welfare Building
Harrisburg, PA 17120

Day Care Services
Dept. of Social Welfare
1 Washington Avenue
Providence, RI 02905

Chief, Day Care
Children and Family Services Division
P.O. Box 1520
Columbia, SC 29202

Consultant, Day Care
State Dept. of Public Welfare
Pierre, SD 57501

Day Care Licensing
Dept. of Public Welfare
State Office Building
Nashville, TN 37219

Consultant on Day Care
State Dept. of Public Welfare
John H. Reagan Building
Austin, TX 78701

Day Care Licensing
Bureau of Family and Children's Services
231 E. Fourth Street, S.
Salt Lake City, UT 84111

Chief Licenser--Day Care
Vermont State Office of Economic Opportunity
43 State Street
Montpelier, VT 05602

Day Care Supervisor
Dept. of Welfare
429 S. Belvedere Street
Richmond, VA 23220

Day Care Supervisor
Family and Children's Services
P.O. Box 1162
Olympia, WA 98501

Day Care Unit
State Dept. of Welfare
1900 Washington Street, E.
Charleston, WV 25305

Director, Day Care
Division of Family Services
State Office Building
Madison, WI 53702

Day Care Supervisor
Division of Public Assistance
State Office Building
Cheyenne, WY 82001

APPENDIX B
RESOURCES FOR CHILDCARE

THE DAY CARE AND CHILD DEVELOPMENT COUNCIL OF AMERICA, INC.
1980 PUBLICATIONS LIST

A50. *Program Planning Aids for Day Care Centers*. Illustrated. 1972. ($3.50)

A51. *It's a Small, Small World, but Larger Than You Think*. John Prondzinski and Stanley Roth. 1974. ($3.50)

B51. *Standards and Costs of Day Care Programs*. 1971. ($.75)

B52. *The Costs of Child Care: Money & Other Resources*. Mary Rowe. 1972. ($3.00)

C50. *Developmental Curriculum*. Lucia Ann McSpadden. ($3.75)

E50. *Interdisciplinary Team Consultation in Day Care*. Luna B. Leach. 1972. ($3.25)

E52. *Guidelines for Observation and Assessment: An Approach To Evaluating the Learning Environment of a Day Care Center*. Illse Mattick and Frances J. Perkins. 1974. ($4.95)

E53. *Formative Evaluation: Parents and Staff Working Together To Build a Responsive Environment*. Lucia Ann McSpadden. ($4.00)

E54. *Evaluating Children's Progress: A Rating Scale for Children in Day Care*. ($4.50)

F50. *Family Day Care*. 1973. ($3.25)

F51. *A Family Day Care Study*. Child Care Resources Center. 1972. ($3.50)

F52. *I'm Not Just a Babysitter: A Descriptive Report of the Community Family Day Care Project*. June S. Sale et al. ($5.00)

F53. *Open the Door . . . See the People: A Descriptive Report of the Second Year of the Community Family Day Care Project*. June S. Sale et al. 1972. ($5.75)

F58. *Family Day Care Associations*. Robert Bookman. 1977. ($4.00)

H52. *Children With Special Problems: A Manual for Day Care*. Marilyn Dashe, ed. ($2.50)

I51. *The Infant Day Care Debate: Not Whether but How?* Peggy Daly Pizzo. ($2.25)

J50. The Infant Care Center. Sanford Hirshen and Joe Ouye. Illustrated. 1973. ($2.25)

K57. Careers in Child Care. Shirley Fogarino and Amy Reynolds. Illustrated. 1974. ($2.25)

K58. Families and Children. ($2.25)

K59 Cognitive and Mental Development in the First Five Years of Life: A Review of Recent Research. 1970. ($3.25)

L50. Selected Readings in the Issues of Day Care. James A. Harrell, ed. Photos. 1972. ($5.25)

L57. Toward Comprehensive Child Care. Bank St. Consultation Service. 1974. ($4.00)

L62. Mothers in Paid Employment. James Harrell and Peggy Pizzo, eds. ($4.00)

L66. Analysis and Strategies for P.L.94-401. ($3.00)

M51. Principles of Home Visiting. Staff of the Georgia Appalachian Outreach Project. ($3.00)

N50. Health Services. 1971. ($1.50)

N51. Good Food for My Baby. Peggy Daly Pizzo and Phillip Pizzo, M.D. 1975. ($3.75)

N53. How Children Grow. 1972. ($3.00)

P50. Parents and Teachers Together: A Training Manual for Parent Involvement in Head Start Centers. Larry Rood. 1970. ($4.00)

P51. Parent Involvement Staff Handbook: A Manual for Child Development Programs. C.M. Lundberg and B. Miller. 1972. ($3.25)

P52. Baby & Other Teachers. May Aaronson and Jean Rosenfeld. 1975. ($3.75)

P53. How Babies Learn to Talk. P. Pizzo and J. Manning. 1974. ($3.75)

P55. Checking Out Child Care: A Parent Guide. J. Gold and J. Bergstrom. ($10.00 for bulk pack of 20 copies or $.75 each)

R51. Zoning for Day Care. 1972. ($1.25)

R52. Regulation of Early Childhood Programs. Gwen Morgan. 1971. ($4.25)

S51. Operational Difficulties of Group Day Care. Peggy Daly Pizzo. 1972. ($2.25)

S52. Day Care Proposal Checklist. 1973. ($1.00)

S55. A Study in Child Care: 1970-71. Abt Associates. 1970. ($1.00)

S56. Children on Campus: A Survey of Pre-K Progress at Institutions of Higher Learning in the U.S. B. Greenblatt and L. Eberhardt. ($5.00)

T50. What Do We Believe About Child-Raising? Thoughts for Child Care Staff Development. J.R. Staffieri. 1973. ($2.25)

V1. Day Care Services: Industry's Involvement. 1971. ($.75)

V51. Realities & Fantasies of Industry-Related Child Care. 1973. ($3.50)

W50. Starting Out Right: Choosing Books About Black People for Young Children. Bettye I. Latimer, ed. 1972. ($3.25)

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11.

Parenting and Child Services for Drug Dependent Women

Nina R. Lief, M.D.

This chapter will describe how to organize, administer, and evaluate parenting programs for chemically dependent women and their children. Specifically, it describes a parenting service developed and administered by the Pregnant Addicts and Addicted Mothers Program (PAAM) in New York City. Relevant literature is presented, including studies that provided a theoretical basis for PAAM. Next, the 12 themes used in the parenting curriculum are discussed. The themes are organized into three distinct categories: what parents do for the child, what parents derive, and what children derive from parenting.

The chapter also explains the procedures involved in establishing the parenting program, the staff and physical setting required, and methods of stimulating client participation. Information is presented on the objectives and various parenting activities conducted during the different phases of the child's life. The last section discusses the assessment and evaluation instruments used, the preliminary conclusions drawn, and implications for the field. The material in this chapter is based on work with opiate abusers, but the information generally applies to work with other chemically dependent populations.

THE NEED FOR PARENTING SERVICES

The need for parenting services in the drug field has been well documented in the literature. Studies have shown that children of drug-abusing women are at high risk to have developmental, behavioral, and psychological problems (Carr 1975; Mondanaro 1977; Nichtern 1973).

Wilson (1976), who studied the growth and development of narcotic addicts' infants for more than 10 years, concluded that highly active measures are necessary to effect successful parenting in the drug-abusing family. She reported that the parenting relationship is hampered by the addicted mother's inability to respond with sensitivity to the infant as well as by the infant's early unresponsiveness to the mother. Wilson and McCreary (1976) found that behavior disorders, emotional problems, and learning disabilities often result from the "disorganized system of communication" between the addicted mother and her child.

An addicted mother's interaction with her newborn in the immediate postpartum period may be hampered by several factors related to drug intake during pregnancy and just before delivery. She may be experiencing withdrawal symptoms or may be feeling groggy and unresponsive from a mixture of illicit drugs and any analgesics or anesthetics administered to her during labor. Her condition may prevent her from behaving with her newborn in the consistent and responsive manner needed to initiate a successful nurturing relationship. She may have difficulty in making direct eye contact with her baby; she may hold the infant away from her body, preventing close skin contact; and she may find it difficult to be vocally stimulating and reactive to her newborn.

Following discharge from the hospital, the mother often faces complicated social problems. Child protective agencies, for example, may challenge her right to custody of her baby. Such social pressure is likely to increase the mother's irritability as she relates to her infant.

The establishment of a successful interactive relationship may be further threatened by the physical state of the newborn. Babies born to addicted women show a high incidence of prematurity and low birth weight. They may be born passively addicted to narcotics and undergo mild to severe withdrawal shortly after birth. As yet, the long-term developmental sequelae of intrauterine narcotics exposure have not been established. If the baby is experiencing some degree of withdrawal, s/he may display one or more of the following symptoms: irritability, hyperactivity, resistance to holding, tremors of the extremities, vomiting, diarrhea, elevated temperature, and poor sucking efficiency (Finnegan et al. 1973; Rajigowda et al. 1972; Reddy et al. 1971; Zelson et al. 1971). The treatment of the baby's withdrawal may require hospitalization, which could seriously interrupt the early interactions considered necessary to establish healthy psychological bonding between mother and infant.

Mothers studied in a methadone maintenance program reported that their babies were continuously irritable, excitable, and unable to nap and experienced sleep irregularities (Lodge et al. 1975; Mondanaro 1977). Thus, a combination of neonatal and maternal factors can seriously threaten the quality of early interactions between drug-addicted mothers and their babies. Such disturbance in the early bonding process may have long-term consequences for the child's physical, cognitive, and emotional development (Klaus et al. 1975). Although the child's florid symptoms diminish as withdrawal abates, they may linger to some degree throughout the newborn period. The mother, once at home with her baby, may quickly perceive that she has a "difficult" baby on her hands, one who is highly irritable, not easily consoled, and difficult to manage.

Often, the new mother lacks knowledge about infant care and child development. Accustomed to a chaotic and unstructured lifestyle, she may be hard pressed to meet the baby's need for order and routine. Bringing home a new baby is generally stressful for any family. When the baby has problems and the family already is burdened by the limited personal and financial resources associated with addiction, the situation is likely to be overwhelming. These special features of addiction make a program of parenting and childrearing essential for drug-abusing families.

THE PAAM PROGRAM

The PAAM program is a component of the Center for Comprehensive Health Practice of New York Medical College, a large, self-contained multidisciplinary clinic that provides primary health care to residents in East Harlem. Therefore, PAAM provides comprehensive care for pregnant addicts and their families, including obstetrical, psychological, pediatric, and family services.

In 1969, New York Medical College began a pilot childrearing project serving mothers and babies monthly for 3 years. Based on early findings that showed improvements in the families served, expansion of the program seemed justified. Because public funding was not available at that time, New York Medical College decided to join forces with the New York Junior League, which provides volunteers, services, and fundraising assistance.

Although the PAAM program requires more staff and involvement than many facilities are able to provide, the parenting component can be replicated in more modest arrangements. In this chapter, we will describe parenting procedures that agencies can modify to suit their own needs.

PARENTING CURRICULUM

The parenting curriculum developed by PAAM is based on 12 themes. We will discuss the rationale for these themes and show how they can be integrated into a parenting curriculum designed to improve the mother-child relationship and the quality of care for the child.

CHILD DEVELOPMENT LITERATURE

Agencies that plan to develop parenting programs for chemically dependent women and their children should first become familiar with the appropriate child development literature, which provides the theoretical basis for parenting curriculum. Topics that should be of interest include the following:

- The critical influence of care given to the child during the first 3 years of life (Bloom 1964; Hunt 1971; Lidz 1968; Stone and Church 1968);

- The complexities of psychological growth (Danziger 1971; Goslin 1969; Talbot et al. 1971; Zigler 1969);

- Empirical studies on maternal competence and role, on developmental processes, and on the interactive forces that help shape personality structures (Auerbach 1968; Beadle 1970; Bijou 1970; Brim 1965; Danziger 1971);

- The influence that children have on the care they are given (Bell 1971; Brody 1956; Escalona 1968; Murphy 1962; Newson and Newson 1968; Wilson 1972); and

- The importance of parents' recognizing variations in child behavior (Thomas et al. 1968).

PARENTING THEMES

The PAAM childcare curriculum is organized into themes that can be varied in response to the highly individual flow between parent and child. The first six themes concern parental input, the next three deal with parental attitudes, and the last three focus on the child's emotional development. These themes are used to apply developmental knowledge, to guide discussions with mothers, and to assess childcare patterns observed in work with parents.

The curriculum encompasses the crucial areas affecting emotional and intellectual growth including: physical care, patterns and sequences of care, motor and sensory stimulation, promotion of communication and language, exploration, social relations, interest in achievement, enjoyment of the child, confidence in the maternal role, establishing security, handling separation, developing conscience mechanisms through consistent limitation and approval, and stressing self-esteem. These themes are continuous processes in the mother-child relationship, and they focus on the quality of parental input that is associated with a well-developed child.

Physical Care. It is well documented that serious psychological damage can be caused by deprivations to the biophysical system of the child (Birch 1970). Proper nutrition and hygiene practices and routine pediatric care are preconditions to psychological health and basic responsibilities of the parent. An infant or child whose physical discomforts are kept to a minimum has a better chance of responding vigorously to a stimulating environment, acquiring a positive outlook, and engaging in a broad range of experiences. For the most part, parents excel in this category of caregiving, and it is reflected in their young. There is a tendency, however, to regard this parental function as the sum total of baby care during the first few months, and many parents remain oblivious to important psychological needs. This narrow view of the infant should be replaced by a broader outlook that relates the physical to the mental. The addicted mother shares in this attitude and often needs more specific instruction in baby care, a fact that has been recognized and appears in the PAAM curriculum. With this added information, the addicted mother often does as well as the nonaddicted mother, and in some cases better, because to her a healthy baby is the visible measure of her success as a mother.

Patterning and Sequencing. By maintaining an organized but relaxed time schedule in a patterned order of care, and by carrying out pleasantly repetitive acts during feeding, bathing, playing, and bedtime, the parent provides the child with a predictable environment that helps foster a sense of security in the infant. This sense is highly relevant to the development of basic trust. At the same time, these regularities of events contribute to cognitive growth because they build up certain expectations in the infant, providing a gradual sense of past and present and the beginning of memory.

Although patterning and sequencing of care has been alluded to in some thoughtful reviews of early childcare theories (Smith 1968; Yarrow 1968), there does not appear to be any research bearing directly on this topic. Nevertheless, there is often some reference to the necessity for routines. The Harvard Pre-School Study (Litman 1969), among others, found that a disorganized home and lack of daily care schedules were important factors contributing to low competence among 3-year-olds when compared with the lives of highly competent children. A relevant experiment by Bresnahan and Blum (1971) demonstrated how chaotic reinforcement interfered with learning among young children. Our view is that patterning and sequencing are neglected but fundamental concepts in childcare, both for the parents' comfort and for the accommodation to the particular emotional temperament of the infant.

PAAM mothers found that patterning and sequencing were difficult, but once achieved the results were rewarding to them as well as helpful to the baby. Their behavior was influenced by PAAM requirements to obtain methadone at a certain time, to see the counselor, to attend parenting classes, in some cases to call for older children at school, and to attend to their needs as well. They had a more difficult time than did nonaddicted mothers, but a pattern of living was established in time. The PAAM infants were often put to bed later than their conventional time, and their feeding times were also unconventional, but a certain regularity was established that served the family lifestyle.

Stimulation: Motor and Sensory. The parent's face-to-face interaction with the child--holding, fondling, providing things to see and to grasp, helping to engage motor capabilities and perception from the start--is essential. During the child's first 3 years, parents need to increase and continuously change the forms of stimulation and opportunities for learning in order to match the child's maturational and endowment potentials from stage to stage.

Developmental patterns in the sensory motor area have been researched extensively, especially in regard to optimal levels of amount, intensity, variety, and complexity in stimulating cognitive abilities at each age (Bruner 1968; Deutsch 1960, 1964, 1965; Hellmuth 1970;

Yarrow 1968). Piaget's now seminal work (Bayley 1940; Gesell 1940) and other works on detailed age norms are classic examples; Piaget named these early years the "sensori-motor" period, and this emphasis on cognitive development has received the full weight of current scientific investigation. Interestingly, although the emphasis has been on the harmful effects of understimulation, there are also indications that overstimulation may be equally harmful. In a study of infants during their first 3 months, White (1970) noted that although massive enrichment produced early visual and prehension abilities, the experimental infants cried much more than did the control group. After testing various procedures to eliminate negative effects, he concluded that modified or paced enrichment was "the most successful match of external circumstances to internally developing structures."

In PAAM, the mother's attitude was often influenced by her physical and psychological state. Some mothers were very responsive to the concept of stimulation and tried to emulate playing at home with the appropriate toys (red ring, rattle, etc.), which was demonstrated in the sessions. A few infants may have been overstimulated, but in general the majority of mothers needed constant prodding to provide sufficient stimulation with age-appropriate objects.

Stimulation: Communication and Language. Communication begins long before the child acquires speech. Perhaps the earliest communication pattern is formed when the infant's expressions of difficulties by crying and fussing are met by consistent soothing responses of the caregiving person. Learning to smile as a response is another early form. Even before a child uses words, language is developing from the mother or other persons. As the child learns to speak, the style and quality of input become important.

Studies of language development focus on two areas: acquisition of speech as a tool for interpersonal communication, and speech as it is associated with thought processes, i.e., what is taught (Beadle 1970; Lewis 1963). Acquisition of speech--building a vocabulary, naming objects, labeling feelings--is related in research studies to perception and its importance to later communication skills of reading, writing, and social interaction.

The emphasis on the relation of language to thought is a more recent subject of investigation. An impressive experiment was conducted by Hess and Shipman (1965) concerning language used by parents in controlling their child's behavior as it affected performance on a cognitive task. They compared children whose parents used authoritarian control (e.g., "You must not . . .") with those using rational control (e.g., "You should because . . ."). The performance of the rationally controlled children on the task was significantly superior in all aspects. Studies of disadvantaged children in poor families point to similar conclusions. Malone (1967) associated language handicaps with the serious thinking impairment found in the study's preschoolers. It was observed that under massive remedial efforts, language was the slowest to improve. Smith (1968), in a review of Bernstein (1964), suggested that children reared to the restricted code associated with limited working-class speech may not progress in cognitive development from concrete to formal Piagetian operations. Although these studies were concerned predominantly with cognitive capacities, they also showed that language and communication have broad implications for the emotional components of personality.

Because of the importance of speech acquisition, we emphasized this aspect in all our parenting sessions. This is a difficult area for most mothers, but especially for the addicted mother, who has her own difficulties in communication. A great deal of modeling and reinforcement was necessary from the staff to make these mothers value and be aware of the development of speech. They were always more tuned in to motor development and longed for early walking; they thrilled to the baby's first babbling only as we continued to demonstrate the baby's speech activities and showed the mothers how to respond to the infant's attempts at communication.

Exploration. One way infants learn about the environment is through a sort of relaxed, nondirected behavior or exploration. The child who repeatedly throws an object off a table and waits for someone to pick it up is involved in exploring space. Other early exploring tactics include testing everything by looking, tasting, pulling, banging, touching, scratching, and squeezing. Exploratory activities increase visibly as the child begins to crawl and walk. At this time, parents often begin to restrict their children.

The importance of letting children have freedom to explore their surroundings is often mentioned in early childhood literature in connection with creativity and problem-solving capacities. Animal studies of exploratory behavior, especially in relation to problem solving, indicate that learning is best achieved under conditions of reduced tensions (Beadle 1970). In work with children, Piaget (1950, 1970) is most notable for having delineated this kind of behavior in remarkable detail. Litman (1969), in the Harvard Pre-School Study, found parental restrictiveness to be a leading variable associated with low competence in children. Freedom to explore was observed by Murphy (1962) to be important to later development of coping abilities.

The significant influence of mothers on exploratory behavior was demonstrated by Ainsworth and Bell (1972) in a controlled test situation with 1-year-olds. They found that the children engaged in a much more active environmental exploration in the presence of their mother than when with a stranger. In addition, the children who measured highest in exploratory activities had mothers who valued curiosity.

In general, mothers regard exploration as "getting into things" and have a tendency to inhibit children needlessly in the intersts of order and safety. In the case of addicted mothers, this attitude was even more evident, and often the baby was inhibited by harsh language and physical restraint and inconsistency, depending on the mother's state. The infants were also inhibited by a lifestyle that required the baby to be confined to a carriage most of the day as the mother participated in her clinic visits (often requiring traveling long distances), welfare negotiations, and her street activities, which did not cease completely even though they decreased when she was in the PAAM program. With much effort and demonstration, the addicted mothers began to understand the significance of exploration in relation to learning. All of them were eager to have their children succeed later on in school and tried to cope with and encourage the babies' exploratory activities.

Social Relations. Although the infant's interactions are mainly with the mothering adult, his or her field gradually expands to father, siblings, and others. Through guided interchanges with these persons, the child learns to view them as persons rather than objects and begins to gain a repertory of interpersonal skills such as sharing, taking turns, and behaving with generosity. Although cooperative play or casual give and take may be beyond a child's scope in early infancy, children show growing interest in other people, especially other children, partly as a way of self-learning. The security of an assisting adult during these early socializing activities helps to make these experiences positive ones for the child. This enables the child to develop a sense of self as well as differentiated feelings about other persons.

Research in the area of interpersonal relations during infancy is rather minimal; however, specialists in early childhood view the wider and more complex social contacts as cognitive factors in acquiring a sense of self (Caldwell 1972; Dittman 1968). Discussing his observations of 2-year-olds in day care, Neubauer (1968) suggests how interaction with peers can affect a child:

> The more the group is seen as consisting of individuals in their own right, the more the child is able to find his own sense of self. . . . The child can see the needs of others, observe other means of reaction, confront his fantasies with the fantasies of other children, and give his own explanations for his actions while he hears those of others. Both imitation of others and identification with others in the group are factors leading to differentiation. (pp. 66, 67)

Arranging appropriate social settings for the infants in the addicted population was always difficult. Some had older siblings who exhibited marked rivalry or were made to be unwilling caretakers and were often punitive. In other instances, older children overstimulated the infants and the mothers had difficulty coping with the infants' needs for socialization without being harsh to either younger or older children. In any setting, coping with these problems takes understanding and patience. But these attributes are not part of the addict's personality because her need for immediate gratification is involved as well as the child's. The PAAM program had to spend considerable time in this area until a mother could learn to establish appropriate ground rules and adhere to them.

The opposite situation occurred with some single parents who lived alone with their infants. These infants often had little opportunity to play with another child except at the PAAM center in the parenting session or the waiting area.

Parental Attitudes: Interest in Achievement and Mastery. Interest in what their infants can do, active involvement in eliciting such behavior, encouraging the infants and offering standby assistance patiently so that they might master certain tasks, teaching goal-directed activities, and measuring out frustrations according to the child's capacity are some of the parental behaviors associated with this cateogry. Although interest in achievement represents a value that parents hold in varying degrees, we often see parents who express interest but who have little understanding about their part in influencing this trait. In particular, they are not aware of what achievement is. The child's accomplishments, such as building a tower or trying to eat independently, are seen as idle play and are not recognized as achievements.

Several years of experiments, spurred by McClelland (1953), on how achievement and mastery are equipped and motivated showed the importance of parents' beginning training early in the child's life (Hunt 1971; Kagan 1971). Although there is disagreement about the nature of this motive (Crandall 1972), an example of more recent research finds that, for boys at least, the lack of drive for achievement and mastery is associated with low parental interest and acceptance coupled with high parental punitiveness (Katz 1967).

A major finding in a British survey of 11,000 7-year-olds leads to the similar conclusion that lack of parental interest was closely related to low reading scores and, further, that this finding is true across social classes (Pringle et al. 1967).

The addicted mothers were interested in their infants achievements when progress was pointed out, and as their level of awareness increased they were able to recognize their part in these achievements--at least at times, we were able to elicit smiles of satisfaction from them. The entire staff made every effort to reinforce this interest by our own recognition of the achievement.

Enjoyment of the Child as a Person. An important facilitating attitude in giving care is the parents' enjoyment of their child. When they can derive pleasure in promoting the child's growth and unique individuality, it helps them to see beyond the humdrum tasks of changing diapers and preparing formulas. In our project, we attempt to arouse this feeling in many parents who tend to overemphasize the difficulties inherent in childrearing. For example, a mother who complained that she was overwhelmed by the high activity of her newly ambulatory son, who "gets into everything," was offered another view--that he was a healthy, inquisitive child exploring and learning about his environment. At her next visit, the mother expressed great pride and enjoyment of her son's increased activity. This shift in attitude came from what the Newson (1968) study identified as a child-centered perspective.

This topic is often neglected in current childrearing literature. Apparently, parental satisfaction is taken for granted or perhaps--an impression gained from certain problem-centered childcare books--not to be expected. Pavenstedt (1967), in her study on disorganized family situations, noted the damage to the children's sense of identity and self-esteem that resulted from their parents' obliviousness to them as individuals in their own right.

Research interest in measures of maternal attitudes and their effects on children has increased, however (G. Brody 1969; Caldwell and Ricciuti 1973). The Harvard Pre-School Project (Litman 1969), for example, has produced some significant findings based on close observation of mother-child interactions in natural settings. A study of maternal attitudes of high-competent versus low-competent children revealed that this capacity for enjoyment was a significant maternal attribute. In their words, "confident, competent mothers . . . who enjoy and approve of their children were more likely to produce well developed children."

In this area, the addicted mothers rated much lower than other mothers. In view of their harried lives and their own deprivations as children--some never remembered being kissed or hugged by their parents, and some never had a birthday celebration or even a cake. Recognizing this as an important area, PAAM tried to devise ways to evoke this feeling.

Maternal Self-Confidence. The feeling of security in her mothering role, a clear concept of its requirements, and a positive view of her ability to perform it, contribute importantly to the mother's competent behavior in caring for her child. These qualities are especially reinforced for the mother when interaction with her child is successful, which increases her competency as her self-confidence grows.

Many mothers appeared to use our program as a way of confirming their maternal abilities, and we observed that our feedback on their infant's normal growth helped to establish feelings of self-confidence. Occasionally, a mother would enter our program showing very little conception of herself as filling a mothering role. Several were unwed teenagers living with their own mothers and relating to their infants as siblings. These mothers began to get a sense of their role only by watching and listening to other mothers in discussions. Similar results have been observed in other parent education programs (Auerbach 1968; Badger 1972; Brim 1965; Dittman 1968).

Research in role performance has provided evidence that self-confidence is a core quality in competent performance (Sarbin and Allen 1968). The Harvard Pre-School Study confirms this in finding that for their group of high-competent children at age 3, a chief characteristic of their mothers was this sense of sureness in giving care to their infants.

Although the addicted mothers' feelings of confidence increased as the sessions progressed, much work had to be done to assure them that parenting courses were not inflicted on them because they were "bad mothers" but so that they could receive the same advantages offered to nonaddicted mothers. When they were convinced of this, their confidence in themselves as mothers began to emerge. They often asked in what ways they compared with the other mothers, and they could deal with the comparison.

INFANT OUTCOME CHARACTERISTICS

Security and Basic Trust. Emotional development is a complex and intricate process that demands sensitivity and skill from the mother. Newborn infants experience undifferentiated feelings of comfort and discomfort that they express through their movements and sounds. When a mother learns very early to "cue in" appropriately to these expressions, her responses begin the process of establishing basic trust in her infant (Erikson 1963). Many specialists view this process in early childhood as central to the development of healthy affect (Abrahamson 1969; Beadle 1970; Bettelheim 1962; Salk 1971; Spitz 1965) and of primary importance to enhance cognitive development. When this basic feeling of security is positively promoted by the mother through repeated patterns and schedules based on needs, the infant first appears to trust the general environment and then gradually to form a primary attachment to one person.

Attachment to one significant person has many aspects that have been debated by day care proponents (Dittman 1968), but its central thesis as a crucial element in emotional well-being has never been an issue. Agreement on this point is virtually unanimous. Among scientists who have described children deprived of this experience, such as institutionalized infants, Malone (1967) observed that isolated children frequently form an attachment to a place, e.g., a room, that gives them security. The effect was to retard the growth of self-concept, view others in a depersonalized way, and cause serious interference in the kind of exploratory learning that leads to cognitive attainments.

In this area, some of the addicted mothers were able to function a little better than in other areas because they were usually with their babies in the program and were able to respond to their physical needs in a fairly consistent pattern. Also, the mothers yearned for feedback from their babies. They were proud to report the baby's first smile to them and preference for being held by them, as shown by less frequent crying and a sense of comfort.

Separation-Individuation. Attachment behavior that has received attention in studies of both primates and human infants is most notably described in studies of maternal deprivation (Ainsworth 1965, 1969; Bowlby 1951, 1969; Foss 1968; Mahler and La Perriere 1965; Mahler et al. 1975). They found that when attachment and

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its concomitant process of separation was either interrupted or abruptly terminated, young children became typically unresponsive to their environment. Later in their growth, this effect was associated with a range of personality disorders, including delinquent behavior in adolescence.

This early phenomenon, identified in psychoanalytic literature as a phase of separation-individuation, has been detailed in studies of its normal and abnormal courses in personality development. In a close relationship with a person, usually the mother, an infant learns to differentiate various emotional states and to use the security gained from the relationship to go through the anxiety-provoking, gradual stage of separation. During this time, self-identity and autonomy are forming. The process of separation-individuation has been studied and documented by Mahler and La Perriere (1965), Mahler et al. (1975), Pine (1970), and the staff at the Masters Nursery and Institute, based on longitudinal detailed observations of mother-infant pairs. Mahler's conclusions were that the maintenance of the attachment relationship during infancy, without premature separation, made possible a good resolution of emotional conflicts by age 3. By that age, if all goes well, the child will have gained a more complex understanding of reality and a positive sense of environment as he or she begins to cope alone.

Other research has included studies of institutionalized infants who were deprived of these emotional experiences (Provence and Lipton 1962; Spitz 1965) and, at the other end of the scale, studies of overprotected children (Levy 1966; Litman 1969). These studies traced the kinds of emotional damage, at times irreversible, created. Although they may be extreme examples, they nevertheless indicate the problems inherent in this crucial area.

In any group of mothers, the issues of separation and individuation are difficult to deal with, because most parents are ready to separate from their infants long before the infants are ready to separate from the parents. Parents of all socioeconomic and cultural levels find it difficult to respond to an infant on his or her own maturational timetable. This concept runs counter to the parents' emotional readiness and requires considerable discussion and demonstrated experiences to be understood. Some addicted women had to stay with their children because they had no place to leave them; others, at times, just "dumped" them on anyone and then could not deal with the infants' clinging on their return. Some would even leave them sleeping alone in an apartment while they went to shop or visit. This practice happened less frequently as the PAAM parenting program began to have more impact. Even in an addicted group, however, some mothers were well tuned to their children's feelings and responded with sensitivity.

Discipline. The area of conscience mechanisms is concerned with aspects of personality that regulate the self through inner controls and outer responsible conduct. Although conscience (the internalization of controls) and a cognitive sense of "right" and "wrong" belong to a later age when a child has a fair mastery of language, the mechanisms for acquiring self-discipline begin to develop during these early months. Although these mechanisms are shaped by the way in which parents apply external controls and restrictions, even more important forces in this process are the degrees of trust and security and the ties of affection that are being nurtured in the child. These become the emotional background for training.

The parents' approval or disapproval, as the child perceives it, is the fundamental tool of motivation that carries over to all future learning. Behavioral studies of learning (Bresnahan and Blum 1971; Skinner 1953) illustrate the power of positive reinforcement: recognizing approved behavior with rewards and extinguishing negative behavior by deemphasis. Punishment tactics are ineffective under most conditions.

Investigation of other factors related to discipline include cultural values and lifestyles associated with management of aggression and its antecedents in stress and frustration--experiences especially of the preverbal child (Clausen 1968; Fraiberg 1959; Gesell 1943; Kessler 1970; Talbot et al. 1971). In the applied field of childcare, parents often view discipline narrowly as a matter of obedience and enforcement methods, whereas specialists see discipline as a subject of much controversy (Zigler and Child 1969). The Newsons (1968), in their survey of parents of 4-year-olds, found discipline to be the most difficult and sensitive subject for parents to discuss. Much discussion revolved around the issue of control (permissiveness versus strictness), and more than half the mothers questioned expressed doubt and self-criticism about their performance in this area. These feelings occurred in even greater proportion among middle-class, as compared with working-class, mothers. The mother's self-confidence depends to a great extent on her success in this category of childcare. The ultimate development of conscience mechanisms from this beginning is important to the individual and to the society.

The issue of discipline is one of the most difficult for addicted parents to deal with because discipline has been a prime factor in their maladaptive pattern of living. In most cases, their experiences have been with impatient, harsh, and ineffective discipline techniques. This is the parental model they have internalized, so it is extremely difficult for them to take a different approach. Most of them grasp the relationship between their drug use and their life experiences, but the pattern of harsh punitive responses toward children is difficult for them to undo. In spite of that, some progress has been made. These parents resort less frequently to physical violence against their infants, although they still find it difficult to control verbal harshness in tone of voice and vocabulary. We believe, however, that we can diminish, if not prevent, these incidents of child abuse. Assessment of the effect of the development of conscience mechanisms--for which the establishment of discipline through consistent approval and disapproval is the precursor--will require long-term followup on our populations.

Positive Self-Image. As the addicted mother learns to be available and to understand how to respond to the infant's needs, she helps the infant develop basic trust and the ability to separate and individuate on his or her own maturational timetable. By appropriate recognition of approved achievement and consistent limitations, she helps the child on the road to developing conscience mechanisms and a good self-image. This leads to healthy personality development, which is the goal of the program. Its efficacy for parents is attested to in anecdotal reporting; statistical evidence is being collected, but is not ready for publication.

HOW TO ORGANIZE AND CONDUCT A PARENTING PROGRAM

ASSESS COMMUNITY RESOURCES

As indicated earlier, the PAAM pilot program began with the help of the New York Junior League, which provided volunteer staff and help in fundraising. Any agency undertaking to institute parenting groups will find that dedicated volunteers, such as Junior League members, can help carry out recruitment, group leadership, fundraising, and publicity for the parenting sessions. For example, Red Cross volunteers, church groups, and other women's associations can be enlisted for training and service. Each facility should identify and assess community resources and, where possible, enlist their help. "Parenting" is a topic of interest to many people. Recruiting suitable volunteers often depends on the popularity of the agency and the personality, tact, and enthusiasm of the agency staff. The agency also needs at least one well-trained member who can train the volunteers.

STAFF REQUIRED

The trained staff member does not have to be a child psychiatrist. A public health nurse, psychologist, nursery school teacher, social worker, or an educated mother can assume the role with appropriate training.

Each group needs at least a group leader and one assistant. When the children become mobile at 10 or 11 months old, it will be necessary to add one or two play teachers to keep the infants safe and to observe and report on their social, cognitive, and motor development. This care will also allow the mothers more opportunity to give their attention to the topics under discussion. The children are in the same room as their mothers and can make close contact with them when necessary.

The group leader needs to have some training in child development coming from either pediatrics, psychiatry, psychology, education, social work, or nursing fields. The leader must also demonstrate empathy for young children--theoretical knowledge alone is not enough. In addition, each must have been trained according to the appropriate philosophy and procedures before beginning to lead groups. This training is achieved by requiring the staff member to attend sessions of ongoing groups as observers, then as assistant leaders and then leaders. The time necessary to train each leader depends on the experience and personality of the individual. We also encourage mothers who have attended the program for 3 years and whose children are in nursery school to use their training as a possible career ladder in parenting training or related fields.

PHYSICAL SETTING

For infant parenting groups, bassinets, changing tables, diaper pails, and a table and mat for testing and test equipment are necessary. (The Gesell Test[1] has been used by PAAM.)

The equipment should be arranged in a room large enough to contain 10 bassinets and chairs for the mothers as well as the materials already mentioned. The room must be well ventilated, carpeted to limit injury from falls, and simply decorated so as to produce a comfortable atmosphere but not detract from the activities of the session.

When the children are about 1 year old, regular nursery school chairs and tables, age-appropriate toys, and snacks are necessary. For children between 15 and 18 months old, the Gesell testing is no longer done on a high table. These children sit in small chairs at a low table so that the test can be administered to measure advanced development. For more complete descriptions of the staffing, equipment, and testing, please refer to Lief (1979).

ATTENDANCE

All groups begin attending sessions when the infants are about 4 weeks old and meet weekly with the same child development specialist and volunteer assistant leader. The sessions last approximately 1 hour. Illnesses, welfare encounters, lack of money to travel, and the unresponsive state due to drug intake all tend to cause irregular attendance during the early sessions. Indeed, even regular attendance to receive medication is difficult for most addicts to manage. Although the irregularity of their lives makes attendance difficult, they can learn to be more regular, and a pattern is established over time. To help overcome this problem, programs should use inducements to encourage attendance. For example, during the first 4 months, provide a week's supply of formula or milk and a red ring for the baby; at 5 months, give a cradle gym to all whose attendance has been good; in addition, take-home medication for 1 day may be offered for attendance at parenting classes. After 7 months of good attendance, the mother might receive a free movie ticket; at 9 months of good attendance, the baby might receive a drinking cup; and at 12 months, a set of terry cloth blocks for the baby and a gift for the mother. At 15 and 18 months of good attendance, the mother would again receive a gift.

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[1] The Gesell is a test to evaluate language and motor, adaptation and social behavior of infants. The test is described in Gesell, A., and Amatruda, C. S., Developmental Diagnosis: Normal and Abnormal Child Development. New York: Hoeber, 1941.

GROUP SESSIONS

Discussion in the groups centers on the children's physical, emotional, and social development and the parents' role in fostering and enjoying that development. Although the issues of concern are, for the most part, the same for all parents, the way the curriculum is presented will affect the success of a session. The PAAM curriculum has been designed to be presented orally, with the group leader introducing a topic for discussion and then inviting group participation, with members describing relevant experiences. This mode of presentation, however, requires certain attitudes and abilities that are often lacking in the addict population. First, many of the addicted parents lack positive school experiences and thus do not feel comfortable with this classroom-type structure. Second, because the parents have their children with them in the sessions, they must learn to attend to the discussion and to their children simultaneously. This skill, which middle-class parents are able to master in a short time, is extremely difficult for addicted parents. It is necessary, therefore, to make sessions as concrete as possible, combining demonstration, group participation, and the use of audiovisual equipment.

In addition to differences in mode of presentation, certain specific issues and topics must be emphasized and discussed to a greater degree for the addict population (Lief et al. 1979). For example, some skills that may be taken for granted have to be carefully taught, such as reading a thermometer, administering medicine, preparing nutritious meals for toddlers, and providing consistent care. In addition, some topics of concern, such as the effect of drugs on the infant, and street-life-related issues, such as dressing the baby adequately for the outdoors, and the effects of multiple caregivers, should be added to the curriculum. For example, in discussing the importance of establishing a consistent pattern in the baby's life, the group leader might first ask parents to describe a typical day's activities. The schedules they describe may be highlighted in a concrete way by listing activities and their sequence in the day's events on the blackboard. The parents seem to enjoy contributing items to such lists, and they say that sharing personal information helps them be part of the group and enhances their positive self-image as parents.

As indicated earlier, the parents experience difficulty in establishing a regular pattern and sequence to their daily activities. Most have led relatively unorganized lives before their babies were born and do not know how to plan a schedule or organize a smoothly running household. As parents describe daily activities, the group leader should help them first to rethink and then to rearrange daily events to better suit both themselves and their infants.

After this exercise, the group leader can ask the question, "Why is this arrangement important?" At this time, the general concept of basic trust is introduced. The group leader explains that the infant learns to feel secure, relaxed, and trusting of others when experiences are predictable and organized in a regular fashion. Children whose lives are chaotic whirlwinds of unpredictable events never learn to trust that others will meet their needs and take care of them regularly. Children who are handed from caregiver to caregiver, who never sleep in the same place two nights in a row, and who receive feedings haphazardly have difficulties in establishing feelings of confidence in their caregivers--and their capacity to establish basic trust is limited. This characteristic may remain throughout their lives. When examples of this type of distrustful personality are pointed out to the mothers, they begin to understand the significance of the issue, which helps them alter some of their patterns. By trying to organize the day for the baby, they will find they are also organizing a better way of life for themselves.

The first activity of any session is for the group leader or assistant group leader to administer Gesell tests to infants who reach a designated testing age. Each child is tested in this way once a month, with the mother participating and observed by the rest of the group. The testing has several purposes. First, it provides longitudinal data on the child's progress over time. Second, it provides an opportunity to alert the mother to any lag in a particular area of development and to help her overcome this lag; moreover, it also alerts her to achievement of expected norms. The mother is also told what to look for in the month ahead and how to enhance development by suitable responses and recognition.

Following the testing, there is a review of the previous week's topics and a discussion of items of concern. The group leader asks about the mother's attitude toward her infant, her feelings about being a mother, her infant's responses, the family situation, and the way the infant fits into the family's lifestyle. Items described in the section on theoretical background are then discussed with the group.

To assess the impact of the curriculum on the participants, we have developed a scale called the Maternal Interaction Form (MIF) (see figure 1). This form is designed according to the theoretical organization of the curriculum. The first 6 items deal with maternal input. Each of the 12 items is scored on a scale of 1, no evidence; 2 or 3, doubtful or some evidence; and 4 or 5, good or high evidence. The MIF is completed on those mothers whose infants were given the Gesell tests in a particular session. The group leader, with her assistant and the trained observers from behind one-way mirrors (where available), score the mother and summarize the Gesell tests results. Findings on the MIF are then incorporated into the agenda for the following week's session. For example, if the group assessment finds that a mother is having difficulty verbalizing to her child and seems not to be stimulating language capacities, this problem may become a topic for discussion in the next week's session as well as a focus of individual discussion with that mother. In this way, the MIF provides both an objective means of evaluating progress over time and a quick, on-the-spot assessment of difficulties that can be dealt with in subsequent sessions.

1. The Newborn Period. The newborn period is the first topic of the course. In addition to discussing the general format of the classes and providing mothers with a basic orientation to the parenting groups, leaders should devote much of the time spent in the early period to the parents' reactions to parenthood. Discussion should focus on the kinds of adjustments they have had to make to accommodate the needs of a demanding newborn. The parents will generally be anxious to discuss their experiences in labor and delivery and to share their feelings about what it means to have their babies home with them. For many parents, the realities of parenthood will not match their expectations. This problem is not unique to addicted families; most new parents tend to underestimate the responsibilities and commitments of parenting and to romanticize an image of motherhood.

Most addicted parents have a special problem during this period--they leave the hospital before their babies are ready to do so. Many will have difficulty expressing their feelings about watching their babies go through withdrawal and about dealing with babies whose overall irritability they can attribute to their own drug use during pregnancy. This makes parenting harder for them than for most mothers. It is necessary to help the parents to verbalize some of their feelings (guilt, anger, etc.) and to teach them ways to comfort their babies during irritable periods.

An important function of the parenting groups during this early period is to provide emotional and social support for the new parents and to try to help them establish strong nurturing bonds with their infants. They need encouragement, for example, to hold their babies close to them during feeding and to look directly at and talk to them. Because the success of the mother's adjustment to parenthood is greatly enhanced by early successful interaction and positive psychological bonding, it is necessary to help the mother learn how to recognize, interpret, and respond to her baby's cues.

For addicted women, the job of learning to recognize and interpret their babies' needs is complicated by the fact that infants born to drug-dependent mothers often do not send clear messages. Experience has shown that these babies are impaired in their ability to respond to social and other environmental stimuli. Anticipating the neonatal assessments to be described later, we note at this point that PAAM babies were somewhat slower to respond to stimuli and also slower to shut down their responses once stimulated compared with infants born to nonaddicted mothers. Similar observations have been made by Strauss et al. (1979).

A great deal of time should be spent helping the mothers to learn to "read the baby" and respond appropriately to the messages received. They should be urged to speak slowly and softly to their babies and to be as calm as possible in handling them. Methods of comforting irritable babies, including how to swaddle them and to soothe them with calming physical interaction and slow soft verbal interaction, should be demonstrated. Such skills are particularly important in the initial newborn period, when the effect of intrauterine drug exposure may be greatest and the infant's first interactions with the mother are critically important.

2. The Period From 1 to 3 Months of Age. This period occupies the second part of the course. After parents and babies have negotiated the newborn period, they seem to settle down to dealing with problems associated with the daily rigors of childcare. During these months, much of the time should be focused on helping parents establish consistent patterns. Practical information on feeding, burping, bathing, sleeping, diapering, dressing, and cuddling needs to be combined with an introduction to the underlying concepts of child development that relate to the practical advice being offered.

During this period, several sessions should be devoted to health care and how to use a pediatrician. Such matters are extremely important for addicted families because most of them have never been exposed to consistent care themselves and are not familiar with how to make the best use of routine well-baby care. In addition, some time is spent on recognizing and handling emergency situations for young children. These topics should be repeated at various intervals throughout the curriculum.

3. The Period From 4 to 6 Months of Age. This time represents an extremely receptive and expansive period in development for the baby. Many initial physiological adaptations to the extrauterine environment have been made. General patterns of activities have been established, and most are exploring their worlds in an active fashion. The baby has achieved enough physical maturity to be much more than a passive recipient of caretaking. Many have been able to roll over from their backs by themselves, providing them with a sense of control and mastery over the environment that encourages exploration. Some may be able to sit by themselves, and most have achieved enough control over their hands to start reaching and grasping new objects to investigate.

For addicted parents, this time represents an enjoyable and exciting period. The baby has become a more predictable individual, and an initial relationship usually has been established between parent and child. The child enjoys being played with and is more recognizable as the "Gerber baby" many had expected their newborns to be. Because the child is vocalizing more during this period and may actively seek out social interactions, many mothers feel gratified by the baby's response to caregiving. For some mothers, the experiences during this period are extremely powerful in building their self-esteem and their feelings about being "good parents."

This developmental period also is critical for the establishment of certain fundamental patterns in the baby's life and for the early establishment of positive interactions. Mothers should be advised on how to begin feeding regular milk and how to introduce their babies to solid foods.

Mothers should be urged to arrange their daily activities so that mealtimes are enjoyable for them and their babies. Children whose mealtimes are special events to enjoy with their parents are happier and less likely to develop eating problems. Addicts usually eat irregularly--"catch as catch can"--on the street corner. Group leaders must point out that a regular sequence of mealtimes is a central area of organization in infancy. A child who eats haphazardly may grow up to be an adult who is unable to organize his or her life. Showing parents how the present handling of their infants can affect development and influence their future years is an impressive point and can be effective in motivating parental behavioral change.

In addition, mothers need to be shown in a concrete way how to play appropriately with their babies during this period. Through the Gesell testing and other demonstrations, parents can learn what babies can do at this stage and how to gear play activities to promote cognitive and emotional development. In some classes, giving out age-appropriate toys and materials and discussing and demonstrating ways to make simple toys at home are essential.

This is the time when parents are likely to reassess their own life situations. After some of the hurried adjustments to parenthood that took place in the first few months of the child's life, many parents now enjoy discussing and thinking about the changes that have occurred in their lives. Discussions of self-esteem should be encouraged, especially of feelings about being a "good parent" and overall family interactions with parents, spouse, other children, relatives, and friends. It is also important to discuss changes in drug usage and street lifestyle. These discussions usually are lively and animated and are likely to extend over several class sessions. The topics discussed should be brought up and reinforced in individual counseling sessions, in which issues that may be hard for some people to discuss in a group setting are explored in depth with the counselor.

4. The Period From 7 to 12 Months of Age. This period is much more difficult than the previous stages because the children pass through several developmental phases in this interval that may be hard for parents to deal with and understand. As the children become proficient in their perceptual development, they begin to distinguish strangers. Multiple handling, especially by unfamiliar adults, greatly disturbs some babies.

As the babies become more mobile--as they learn to crawl, stand up, and perhaps walk--many become fearful when they realize they have moved away from their parents. It is difficult for a parent of a baby this age to deal with alternating aggressive exploration and fearful clinging behavior. The parents should be given emotional support and practical advice on how to arrange situations so that the child is made more comfortable in this period. Through discussions and demonstration procedures, an attempt should be made to help parents meet their children's dependency needs so that their sense of basic trust and ability to explore their environment will be further developed. For the most part, these dependency needs were not met for the addicted mothers as children. As these mothers recall their own early lives, they begin to understand themselves better and become more sensitive and less impatient with their babies' needs.

Through Gesell testing and talks with individual mothers, group leaders should emphasize the positive aspects of this period of development. Mothers should be told about the children's growing sense of discrimination and social responsiveness and advised on how to predict and prevent situations that create anxiety-provoking responses.

Other discussions should focus on the physical implications of the baby's new mobility and methods of baby-proofing homes. Mothers should be encouraged to plan their home lives so that their babies may safely move about and learn from the world around them. It is imperative to teach some elementary concepts of setting limits and suggest that parents try to offer substitutes for whatever they do not want the child to do. Much work in this period foreshadows later discussions of discipline and the teaching of right from wrong in ways that help children develop internal controls rather than simply respond to external controls.

During the second half of the first year, much effort should be devoted to reinforcing many of the concepts introduced earlier and showing parents how to integrate these concepts into daily routines on a somewhat higher level. For example, in dealing with appropriate stimulation, parents are shown how to play with their babies on the floor, how to make and work with simple manipulative toys, and how to stimulate language development. Again, leaders must deal extensively with the parents' own reactions, emphasizing changes in lifestyle and self-image. Just as mothers must try to understand the child's ambivalent responses to physical separation from parents, they must also learn to understand their own responses when their children begin to move about and away from them. It is important to capitalize on the fact that separation anxiety is an interactive set of feelings emanating from both parents and children.

At the end of the first year, the program should outline the kinds of changes parents can expect from their children in the months to come, paying particular attention to areas that parents are prone to rush, such as weaning from the bottle and toilet training. Harsh weaning and toilet training have been implicated in later psychological dysfunctioning. In some cultures, early toilet training is considered a measure of parental success, and this belief needs to be deemphasized.

As children approach their first birthday, it is profitable to spend time reviewing the progress they have made and reinforcing the parents' sense of having done a good job with their children. This discussion helps parents to prepare for the first birthday party and makes it a special event for both parents and children. Many of these parties can be held in the group sessions, and the parents can help organize and contribute to party activities.

The part of the curriculum that covers the infant's second year is divided into two parts: 13 to 18 months and 19 to 24 months.

5. The Period From 13 to 18 Months of Age. Topics addressed during this period include the baby's learning to walk and the resulting mobility and exploration, language development, disciplinary techniques and limit-setting, and the difference between discipline and punishment. Throughout, emphasis should be on helping the mother recognize the emergent stages of the child's development so that she can respond in a way that will foster normal cognitive, emotional, and social growth.

6. The Period From 19 to 24 Months of Age. At this point, the child has begun to achieve a certain degree of autonomy. Aspects of the child's behavior such as play, sleep problems, and temper tantrums are addressed. Mothers must be taught that the behavior of the "terrible two's" is to be expected and that there are nonpunitive means of dealing with these behaviors.

If resources are available, the program should establish a preschool program during the latter part of this period. It is recommended that preschool nursery group sessions for mothers be held once a week. These sessions should deal with such topics as sibling rivalry, toilet training, and discipline. An important focus of these sessions should be on how to prepare a child for school and how the mother should relate to teachers and other school personnel. When a child reaches school age, the nursery supervisor should accompany the child and mother to the school to help them through the enrollment process. This additional service may not be possible in all programs, but it has proven so helpful at PAAM that it should be considered as important as the initial parenting sessions. In some programs, this may be the only service that can be offered to the addicted parent and her child; however, even this will be of great assistance. This service can become part of the overall treatment program, possibly as part of the initial introduction to parenting classes.

The next section describes the assessment program being used at the PAAM project. A successful parenting program can be carried out without this assessment, however.

ASSESSMENT AND EVALUATION OF INSTRUMENTS IN THE PAAM PROGRAM

INFANTS

The developmental progress of children born to mothers in the PAAM program is monitored in the first weeks of life by the Brazelton Scales of Neonatal Behavior and later by the Bayley Scales of Infant Development.

The Brazelton Scales assess the newborn's ability to respond and adapt to physical and social environments. From the full Brazelton assessment, the PAAM program selected seven items to assess the infant's responses to various stimuli and to social handling: inanimate-auditory response to a rattle, animate-auditory response to the human voice, inanimate-visual response to a red ball, animate-visual response to a human face, response decrement to a repeatedly presented auditory stimulus, degree of "cuddliness," and capability of consolation.

The Brazelton Scales are usually administered within the first 2 weeks of life. If the infant shows signs of withdrawal, assessment is delayed. Testing is done 1-1/2 to 2 hours after feeding, usually in the morning. All sessions are conducted in a quiet room adjacent to the nursery. The state of the infant before handling is noted. The blanket is removed and any change in state is recorded. The remainder of the examination is carried out with the infant dressed only in a diaper.

A stimulus is presented, and the baby's behavior is watched for signs of responsiveness. Attending behavior is noted by startled responses, changes in blinking or respiratory rate, and visual focusing. With one of the stimuli, the rattle, the baby's ability to adapt to its repeated presentation is noted. The rattle is presented as many as 10 times, with a 5-second interval between presentations. Following some initial attending responses, the baby normally "learns" the stimulus, becomes accustomed to its novelty, and no longer accords it any orienting and attending responses in a pattern of "response decrement."

After the orientation and habituation behaviors have been noted, the infant is picked up and any proprioceptive adaptations, such as nestling into the crook of the examiner's arm, are noted in terms of the baby's "cuddliness." Finally, the last stage of the examination involves determining the baby's degree of consolability by noting the kinds of things the examiner must do to calm the infant and stop his or her crying after an upset. A noxious stimulus, such as a token slap on the foot, is presented to the child, and the examiner tries to calm the child first by talking, then by holding a hand on the child's belly, then by restraining the child's arms, and so forth. Consolability is measured by the degree of examiner intervention necessary to calm the infant.

Although there are no official published standards for the Brazelton instrument, data in the test manual may be taken as approximate norms. We find that PAAM babies are somewhat slower than normal to respond initially to stimuli, and having once attended they are slower to adapt and decrease their responses to the repeatedly presented stimulus. In addition, PAAM babies seem somewhat less cuddly and less easily consoled than do normal babies. Although PAAM babies will generally mold to the examiner, they need a lot of nestling and cuddling from the examiner before they will produce a response. In addition, PAAM babies appear to be abnormally irritable and need to be picked up, held, and rocked to calm them (Brazelton 1973; Lodge et al. 1975).

In examining correlations of Brazelton scores with some other measures of the PAAM mothers and babies, we find negative correlations with indices of maternal and neonatal drug intake. For example, the mother's methadone dose at the time of delivery showed a significant correlation with the infant's response to the rattle. In other words, the higher the mother's methadone dose, the less responsive the infant. We found also that babies who required pharmacotherapy for the treatment of withdrawal tended to show lower scores in their response to the red ball, and they were also less cuddly. It is interesting to note, however, that mothers of infants who had relatively poor scores on the Brazelton Scales were generally anxious to seek help and were likely to show high attendance at parent education classes during the child's first year.

The Bayley Scales of Infant Development are used to assess the cognitive development of PAAM children past the age of 1 month. These assessments are made by a trained psychologist, who maintains standardized conditions for test administration and scoring.

The Bayley Scales are widely used objective measures of intellectual performance. They have been extensively validated, and normative data yielding developmental quotients are available (Bayley 1969). These scales, designed for use with infants and toddlers from 1 month to 30 months of age, yield information for two related scores: a Mental Development Index (MDI) and a Psychomotor Development Index (PDI). Scores for both these indices have been obtained from PAAM children at 3, 6, and 12 months of age. In our sample we have analyzed data from full-term babies who had no complicating factor at birth other than drug withdrawal. We first examined our pool of data cross-sectionally and then examined those who attended for an entire year as a longitudinal subsample.[2]

With a mean score of 100 as the norm for both indices, the findings indicate that as a group the PAAM babies showed normal development through the first year of life. The longitudinal data on the subsample of 21 infants show virtually the same pattern of scores, indicating that as PAAM infants mature they follow a basically normal course of development. Neurological examinations done at the same intervals also have shown normal development.

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[2] Only preliminary findings are referred to here. Statistical analysis will be published separately when completed.

The Bayley and neurological findings indicate that the relative cognitive impairment exhibited earlier on the Brazelton Scales is transient and unrelated to later developmental status. Furthermore, we found that in correlating assessment scores with infants' birth weights, babies of lower weight were likely to have lower scores in the early assessment periods, but that these relationships were no longer present by 1 year of age. This finding is in contrast to the general findings of low-birth-weight infants, for whom cognitive performance remains impaired for at least 2 years of life and may even become worse if environmental conditions are not conducive to healthy development (e.g., Drillian 1964).

We find, then, that in general the PAAM infants who suffer initial deficits overcome them. The measures that show this favorable result are available to us only through parent education classes that teach parents how to promote normal development for their children. We cannot state certainly that the parenting classes were responsible for this result, but we see little ground for reasonable doubt of their value for the children.

Some of our subjects have now reached the age of 3.[3] Figure 2 shows an outline of the test batteries.

MOTHERS

To judge by the public image, opiate addicts' chances for development in conventional roles are poor, and the role of "good parent" would seem to be especially out of reach. Addiction often is cited as a factor in cases of child abuse and neglect. Foster placement among children of addicts is characterized by long periods of placement and poor adjustment, with more behavioral problems emerging than are typically found for foster children who did not come from addicted families (Densen-Gerber and Rohrs 1973; Fanshel 1975).

Our experience at PAAM has indicated that the stereotyped image of the inadequate addict parent is not necessarily true. Almost all PAAM mothers retain custody of their babies. In parenting classes, they prove themselves capable of learning about developmental issues and responding to the needs of the growing infant. Many develop sensitivity to the physical, social, and emotional needs in their children and make concerted efforts to adapt their lifestyles to meet these needs. Many express insights about aspects of their life histories that have negatively affected them and tell of their resolve to prevent similar problems for their children. Many were themselves poorly nurtured as children. Their own dependency needs were not met at appropriate times in their development, and their levels of emotional maturity as adults were limited by their

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[3] These findings also will be reported in a future publication.

BIRTH--for 1- and 3-Year-Old Subjects

Review of Hospital Chart

1-YEAR-OLD SUBJECTS ONLY--administered between ages of 11 and 13 months

Child Development Measures
1. Bayley Scales of Infant Development
2. Flint Infant Security Test
3. Bzoch Test of Expressive and Receptive Language Development
4. Assessment of play session with mother

Pediatric Examination
1. 12-month neurological
2. General physical
3. Fat pad measurement and nutritional data
4. Blood and urine tests

Lifestyle Interview with Mother

3-YEAR-OLD SUBJECTS ONLY--administered between ages of 33 and 39 months

Child Development Measures
1. Stanford Binet Intelligence Test
2. Carnegie-Mellon Test of Interpersonal Relations
3. Bzock Test of Expressive and Receptive Language Development
4. Assessment of play session with mother

Pediatric Examination
1. 36-month neurological
2. General physical
3. Fat pad measurements and nutritional data
4. Blood and urine tests

Lifestyle Interview with Mother

Note: All standard tests are available from: Psychological Corporation, 757 Third Avenue, New York, N.Y. 10017.

FIGURE 2. PAAM and comparison subjects--test batteries

childhood experiences. Through interactions with PAAM staff members and by the consistency of attention to their needs as developing parents, many begin to develop their own sense of basic trust and are thus able to foster similar development in their children. They learn how to interact positively with their children and to gear their actions to the children's developmental level.

We have been able to measure the mothers' progress to some extent by using the Maternal Interaction Form (Figure 1) and by administering a series of vignettes of life situations in which the mother had to choose responses to deal with the situations presented to her. On both measures, the addicted mothers showed their ability to deal appropriately as indicated by the difference in responses at the beginning of parenting classes and at the termination. In addition, followup interviews with families about 6 months after joining the PAAM program showed that parents stress most of the concrete information on childrearing they received. Others described the classes as providing emotional support, a place to be with friends, a place for children to play with other children, and as a meaningful activity away from the street. They judged the course to be very helpful to them and to be a positive influence for their children's development.

Because the program involves the entire family, there is also concern about the effects of the parenting these addicted mothers provided for their older children who were born before the PAAM program began. Health care is provided for all family members. Staff members ask about the child's school situation, how the child spends his or her day, where clinic care is obtained, and provisions for social outlets.

Many of these children are brought up in foster care or by other family members. As the mother improves, they are returned to her under the guidance of the PAAM staff. They usually have a history of irregular school attendance and often have behavior problems. A study that compares the outcome for the older children with that of the infants in the PAAM program should be undertaken as a longitudinal study.

CONCLUSIONS

In the context of a program offering comprehensive care to high-risk families, what is contributed by adding a parent education component? Such a course cannot only be beneficial in itself, but is also a means of integrating and potentiating the other program elements. We have found that the long-term, intensive investment of care in each family was worth the effort.

REPLICATION AND IMPLICATIONS FOR PUBLIC POLICY

We believe that this program can be replicated with the use of volunteers and mothers who have gained a fundamental knowledge of childrearing during their attendance and show an inclination to start a career in childcare. This program can be replicated at low cost, a fact that has been demonstrated in three instances.

In one case, the Junior League of a suburban community was assisted by the local Red Cross, which was already giving prenatal courses for high-risk mothers. The mothers then continued at the Red Cross in parenting classes conducted by the Junior League volunteers, following the curriculum described in this chapter. The total cost per family was less than $100 a year. The money was raised by the Junior League and Red Cross in the community.

Another community set up a program that sends volunteers weekly to each participant's home to discuss issues of concern and to demonstrate techniques of handling infants. This program also uses the PAAM curriculum as a resource.

A hospital-based parenting unit is being organized in another community, where the parenting groups will follow the prenatal Lamaze classes already operating in conjunction with the hospital obstetrical department. The volunteers are members of the local Junior League and are being trained by using our curriculum manual, which is available to all interested groups.

Other groups can be set up as part of church outreach programs. The project does not have to be sectarian. The church can merely act as a sponsor for housing the unit, and interested members of the congregation can be trained to serve as group leaders.

Not every community has a medical school that can staff and sponsor such a program, but almost every community has a service organization of some sort that can be enlisted to help in fundraising, finding suitable space, enlisting and training volunteers.

Once a program is started, mothers attending it gain a fundamental knowledge of childrearing. Those mothers who show an inclination to start a career in childcare can be enlisted to continue the project. This prospect of staffing makes it feasible for replication at low cost so that this approach to childrearing can become an integral part of health care and be as much of a child's birthright as safe milk and preventive inoculation against disease. This is the least we owe our children and ourselves to preserve the most precious asset of our society--its children.

APPENDIX
RESOURCE BOOKS

The following list was prepared to help you develop a parenting training component or a lending library on parenting for staff and clients. Most of these books were written for parents and are "self-help" in orientation. A caution: Parenting must always occur within the context of a clear value system--values about acceptable behaviors, disciplinary techniques, lifestyles, etc. These values are likely to vary widely depending on race, socioeconomic class, ethnicity, and culture. Many gender issues need to be considered in raising children. Parenting orientation and strategies also need to change as a child grows older; parenting an infant requires behaviors different from those used with toddlers, preschoolers, 8-year-olds, or adolescents. Some of these books focus on particular ages; some are more general. Some are gender sensitive; others are not. Some are sensitive to racial, class, and cultural differences; others are middle class in orientation, although even these vary in their approach to particular issues. We have tried to note the author's orientation and gender, racial, or cultural sensitivity whenever possible. The reader is encouraged to browse through these books at a local library or bookstore, however, to select those most appropriate for the client groups served. Publishers are often willing to send examination copies for you to evaluate before purchasing them. New books are appearing regularly, and this list is not exhaustive.

Atlas, S.L. Single Parenting: A Practical Resource Guide. Englewood Cliffs, N.J.: Prentice Hall, 1981. ($5.95.)
Practical advice, extensive list of community help organizations, counseling resources, suggestions, and guidelines for helping single parents develop an effective family life.

Auerbach, S. The Whole Child: A Source Book. Toronto, Canada: Academic Press Canada Limited, 1981. ($18.95)
An excellent resource book for information on children from conception to age 12. Gives an extensive overview of parenting books, resources, and materials. Covers everything from first aid to parent theories, toys, and sex roles.

Barber, V., and Skaggs, M.M. The Mother Person. New York: Schocken Books, 1977. ($4.95)
Although it stresses the joys and satisfactions of motherhood, this book is also a guide to confusion, guilt, and anger.

Bell, R., and Associates. Changing Bodies, Changing Lives. New York: Random House, 1980. ($7.95)
Written by the authors of Our Bodies, Ourselves, this book is an open discussion of issues of sexuality for teenagers. Gives information about sex and body development, while also providing an opportunity to hear from other teenagers going through some of the same experiences. Discusses many negative experiences, such as unwanted pregnancies.

Bell, R.Q., and Harper, L.U. Child Effects on Adults. Lincoln, Nebraska, and London: Bison Books in Clinical Psychology, University of Nebraska Press, 1980. ($5.50)
Looks at the parent-child interaction from the child's perspective.

Bernard, S. Joyous Motherhood. New York: M. Evans and Co., Inc., 1979. ($6.95)
Describes a 30-day program for total communication between the new mother and her child under age 3. Presents a program of creative methods for improving the quality of time mother and child spend together.

Bessell, H., and Kelly, T.P. The Parent Book: The Holistic Program for Raising the Emotionally Mature Child. Sacramento: Jalmar Press, Inc., 1977. ($9.95)
Offers effective ways of relating to a child on a day-to-day basis, as well as long-range advice. Covers the major areas of a child's emotional development Helpful for ages from birth through early teens.

Bettleheim, B. Dialogues with Mothers. New York: Arion Books, 1962. ($2.50)
Verbatim conversations between Dr. Bettleheim and mothers, helping mothers discover answers to parenting problems through their own feelings rather than through an expert's advice.

Boston Women's Health Collective. Ourselves and Our Children. New York: Random House, 1978. ($6.95)
A book about the lives and needs of parents exploring the stages of parenthood, the different ways of being a family, society's impact on parents, and sources of support for parenting.

Bowlby, J. Attachment. New York: Harper Torchbooks, 1969. ($5.95)
A definitive work on the child's tie to the mother, it explains why this vital relationship is so crucial to the development of the child's personality.

Braga, J., and Braga, L. Children and Adults: Activities for Growing Together. Englewood Cliffs, N.J.: Prentice Hall, 1976. ($10.95)
Stimulating activities, practical ideas, and creative games that parents, grandparents, teachers, or anyone involved with children can use to encourage self-esteem and intimacy.

Braga, J., and Braga, L. Learning and Growing: A Guide to Child Development. Englewood Cliffs, N.J.: Prentice Hall, 1975. ($3.45)
A practical guide to understanding children's development and stimulating their growth; explains how to aid children in everything from learning to feed themselves to speech and language development.

Brazelton, T.B. *On Becoming a Family: The Growth of Attachment* New York: Delacorte Press, 1981. ($14.95)
Discusses early bonding and the complexity of the developing relationships between parents and the newborn. Starting with the feelings of the parents-to-be, Dr. Brazelton traces the process of early attachment.

Brazelton, T.B. *Infants and Mothers*. New York: Delta Books, 1969. ($7.95)
A sensitive and readable book on infancy and the differences in developmental responses, starting with the uniqueness of each infant's response to life.

Brazelton, T.B. *Toddlers and Parents*. New York: Delta Publishing, 1974. ($7.95)
A continuation of *Infants and Mothers*. This book begins at age 1 year through 36 months, ages at which independence and self-mastery are important issues. Through descriptions of different children of different ages and in different family situations, Dr. Brazelton describes important developmental issues and ways that different families might handle them.

Briggs, D.C. *Your Child's Self Esteem*. Garden City, N.Y.: Doubleday, 1975. ($4.50)
Step-by-step guidelines for raising responsible, productive, happy children with a recognition of the central issue of self-esteem in growth.

Caldwell, B.M., and Ricciuti, H.N., eds. *Child Development and Social Policy*. Vol. 1 and 2: New York: Russell Sage Foundation, 1964, 1966. Vol. 3: Chicago: University of Chicago Press, 1973. ($7.95)
Comprehensive review of child development research with references to research on disadvantaged parents.

Caplan, F., ed. *The Parenting Advisor*. Garden City, N.Y.: Princeton Center for Infancy, Anchor Press/Doubleday, 1978. ($6.95)
A comprehensive guide written by parents and professionals, this book synthesizes the best thinking and current research on all areas of childrearing.

Clarke, J.I. *Self Esteem: A Family Affair*. Minneapolis: Winston Press, 1978. ($7.95)
Describes the development of self-esteem, starting at home in a nurturing interaction between children and adults. Utilizes theories and techniques of transactional analysis.

Comer, J.P., and Poussaint, A.F. *Black Child Care*. New York: Pocket Books, 1980. ($2.50)
Both general and specific discussions of the problems in raising a black child in America. Deals with the emotional and psychological development of the black child from infancy through adolescence, along with childcare advice. Contains a good bibliography.

Delliquadri, L., and Breckenridge, K. Mother Care. New York: Simon and Schuster, 1980. ($2.25)
A book that speaks to the mother's emotional and physical needs through the transition of new motherhood.

Dodson, F. How to Discipline with Love. New York: Signet, 1977. ($2.50)
A parenting guide of flexible strategies for teaching children desirable behavior. Most appropriate for ages 2 to 10.

Dodson, F. How to Parent. New York: Signet, 1970. ($2.50)
Based on a childrearing philosophy that combines love and discipline; good for ages from 1 to 5. Discusses choosing toys, creating an enriching environment, dealing with hostility. Although middle class in orientation, it is a classic.

Dreikurs, R. The Challenge of Parenthood. New York: Hawthorne, 1958.. ($4.95)
A practical approach to parenting based on sensitivity and understanding.

Dreikurs, R., and Cassel, P. Discipline Without Tears. New York: Hawthorne, 1972. ($3.95)
A sensitive and practical approach to disciplining children, with a "Discipline Without Tears" workbook included.

Faber, A., and Mazlish, E. How to Talk So Kids Will Listen and How to Listen So Kids Will Talk. New York: Rawson Wade Publishers, 1980. ($11.95)
Techniques for the development of communication and listening skills between parents and children.

Faber, A., and Mazlish, E. Liberated Parents: Liberated Children. New York: Avon Books, 1974. ($2.50)
Influenced by Haim Ginott, the authors describe how their skills have changed the way they treat their children and themselves without giving specific instructions so that parents can improvise.

Feinbloom, I., and the Boston Children's Medical Center. Child Health Encyclopedia. New York: Dell Publishing, 1975. ($7.95)
An excellent reference book for parents and professionals. Comprehensive information on health maintenance.

Friedland, R., and Kort, C. The Mothers' Book: Shared Experiences. Boston: Houghton Mifflin, 1981. ($8.95)
Candid personal accounts by mothers on the emotional aspects of motherhood.

Galper, M. Co-Parenting: A Source Book for the Separated or Divorced Family. Philadelphia: Running Press, 1978. ($4.95)
A self-help book for parents whose marriage has ended but childrearing responsibilities continue.

Games Babies Play and *More Games Babies Play*. New York: A & W Visual Library, 1981. ($4.95)
Describes games that stimulate and soothe the infant, games that help promote the development of the senses and verbal understanding, and games in which an older sibling can participate.

Gardner, R.A. *The Parents Book About Divorce*. New York: Bantam 1977. ($2.95)
A practical guide to the problems that arise for parents getting a divorce; helps both parents maintain loving relationships with their child.

Gardner, R.A. *Understanding Children*. New York: Jason Aronson, 1973. ($10.00)
Valuable variations and innovations on childrearing theory and practice.

Ginott, H.G. *Between Parent and Child*. New York: Avon, 1965. ($2.50)
Emphasizes the importance of communication between parent and child with a description of empathic approaches to parent-child problem solving. Middle class in orientation and a little dated, but a classic in the field.

Ginott, H.G. *Between Parent and Teenager*. New York: Avon, 1969. ($2.25)
Believes that letting go is the key to peaceful and meaningful coexistence between parent and teenager. With an emphasis on communication, the book describes many of the experiences between parent and teenager.

Greenberg, S. *Right from the Start: A Guide to Nonsexist Childrearing*. Boston: Houghton Mifflin Company, 1979. ($4.95)
Practical advice on how to raise children of both sexes free of the sexual stereotypes that limit development.

Grollman, E.A. *Explaining Divorce to Children*. New York: Beacon Press, 1969. ($4.95)
Valuable information and guidance for teachers, counselors, and other professionals who work with children from broken homes.

Heffner, E. *Mothering*. Garden City, N.Y.: Doubleday, 1978. ($4.95)
With a constant emphasis on the mother as a person, a common sense and insightful discussion of motherhood.

Hendricks, G., and Brooks, T.B. *The Centering Book: Awareness Activities for Children*. Englewood Cliffs, N.J.: Prentice Hall, 1977. ($3.95)
A collection of activities for children and adults to participate in together. The activities are aimed at increasing awareness and intimacy.

Hendricks, G., and Brooks, T.B. The Second Centering Book: More Awareness Activities for Children, Parents. Englewood Cliffs, N.J.: Prentice Hall, 1977. ($4.95)
A further collection of awareness- and intimacy-promoting activities for children and adults to participate in together.

Jenkins, J.K., and MacDonald, P. Growing Up Equal. Englewood Cliffs, N.J.: Prentice Hall, 1979. ($7.95)
Stimulating games and activities that encourage creativity and independence in the preschooler while also examining nonsexist role modeling and living skills.

Kaplan, L.J. Oneness and Separateness: From Infant to Individual. New York: Simon and Schuster, 1978. ($4.95)
An exploration of the inner emotions and experiences of the child, this book also shows how the parent can most effectively respond to the changes in the child's life.

Kleman, G.W., and Rosenfeld, A. Responsible Parenthood. New York: Holt, Rinehart and Winston, 1980. ($14.95)
A comprehensive, clearly written guide to the child's psychological development from infancy through the preschool years.

Knox, L. Parents Are People Too. Englewood Cliffs, N.J.: Prentice Hall, 1981. ($5.95)
Easy to read, insightful approach to parenting and disciplining children.

Kraft, A. Are You Listening to Your Child? How to Bridge the Communication Gap Through Creative Play Sessions. New York: Walker and Company, 1973. ($7.95)
The application of Virginia Axline's playroom techniques in teaching parent-child communication skills. Appropriate for children from 2 through 8 years old.

Leach, P. Your Baby and Child From Birth to Age Five. New York: Alfred A. Knopf, 1981. ($9.95)
Provides detailed advice and information for each stage of development in the first 5 years. Readable and comprehensive.

McBride, A.B. The Growth and Development of Mothers. New York: Harper & Row, 1973. ($1.50)
Discusses the developmental needs of a mother and offers advice on coping with depression, unmaternal feelings, and helping to define new patterns of family life. Thoughtful and practical.

McCall, R.B. Infants: The New Knowledge About the Years from Birth to Three. New York: Random House, 1979. ($3.95)
Radically new information from recent studies on infant development. Very readable, does not tell the parent what to do but rather describes what is going on in the child's mind and body at different stages of development. Simple and direct.

McLaughlin, C.J. Black Parent's Handbook. New York: Harcourt Brace & Jovanovich, 1976. ($10.00; $3.95 paperback)
A guide for black parents that includes issues common to all parenting plus sections on medical problems and genetic diseases common to blacks, black folk medicine practices, and political and economic influences that affect childrearing. It is designed to guide black parents to help their children develop self-esteem and reach their full potential without self-hate in a world that often disparages them. Written in a simple, readable style.

Miller, M. Family Communication: Keeping Connected in Changing Times. New York: Paulist Press, 1980. ($7.95)
Family communication is treated as an art and a skill, with practical exercises, charts, and examples to help with the development of listening and communication skills.

Miller, M. Help Your Child For Life. Niles, Ill.: Argus Communications, 1978. ($2.95)
Helps parents develop tools for helping their children expand creativity, language, and self-esteem.

The Open Home. New York: St. Martin's Press, 1976. ($5.95)
Information to help the parent with the many different roles as provider, nurse, teacher, friend, and play partner. A very practical guide.

Pantell, R.H.; Fries, J.F.; and Vickery, D.M. Taking Care of Your Child: A Parent's Guide to Medical Care. Reading, Mass.: Addison-Wesley, 1977. ($7.95)
A winner of the American Medical Writers Association Award, a comprehensive guide to child health care problems from birth through adolescence. The aim is to develop parental skills and self-confidence in dealing with every day crises. Part II is a series of decision chapters on various childhood symptoms and complaints to help you decide whether to use home treatment or consult a physician. A background page on each medical problem describes the appropriate home treatment.

Pogrebin, L.C., Growing Up Free: Raising Your Child in the 80's. New York: McGraw-Hill, 1980. ($15.95)
Explains raising children in a world of challenge or change. Guidelines for role-free, nonsexist parenting.

Rosenbaum, J., and Rosenbaum, C. Living with Teenagers. New York: Stein and Day, 1980. ($10.95)
Two experienced therapists help parents and teenagers survive the teenage years.

Schlehofer, J. Joy of Parenting. New York: Paulist Press, 1978. ($3.95)
Creative ideas for enjoying the parenting experience, with an extensive author-annotated bibliography.

Seligman, S.M. *Now That I Am A Mother--What Do I Do For Me?* Chicago: Contemporary Books, 1980. ($5.95)
Helpful guide for mothers organizing their lives so that other goals can also be accomplished.

Sills, B., and Henry, J. *The Mother to Mother Baby Care Book*. New York: Avon, 1980. ($5.95)
A nationwide network of mothers, the real experts on childcare, offer day-to-day practical information.

Stollack, G. *Until We Are Six: Toward the Actualization of Our Children's Human Potential*. Huntington, N.Y.: Krieger Publishing, 1978. ($5.95)
An adaptation of Virginia Axline's playroom techniques to the education of parent-child interactions. The first part describes the research and literature, and the second part describes the practical application of the method. Appropriate for children from 2 through 8 years old.

Stollack, G. *What Happened Today*. Dubuque: Kendall Hunt, 1973. ($2.95)
Stories concerning parent-child encounters. The first section of each story describes a typical encounter, and the second section describes what would be a better way of handling each situation as a parent. Appropriate for children from 2 through 8 years old.

Thomas, G. *Parent Effectiveness Training*. New York: Signet, 1970. ($5.95)
A method to bring parents and their children together, showing parents how to help their children mature. Very good for communication skills with children of all ages, but is especially appropriate for adolescents.

Thomas, G. *P.E.T. in Action*. New York: Bantam Books, 1976. ($2.50)
Basic P.E.T. techniques, plus new solutions for parents who have used P.E.T.

Tronick, E., and Adamson, L. *Babies as People: New Findings on Our Social Beginnings*. New York: Collier Books, 1980. ($7.95)
Written from the perspective that infants are born responsible and "eager to learn," expressing their uniqueness. Examples and insights into the interdependency of the baby/adult relationship are given.

Weiss, R.S. *Going it Alone*. New York: Basic Books, 1979. ($13.95)
Discusses the issues and problems of raising children as a single parent with both empathy and objectivity.

Welch, D., and Hughes, W. *Discipline: A Sheaf of New Ideas for Parents and Teachers*. New York: Hart Publishing, 1977. ($3.95)
Discipline skills based on empathy and understanding.

White, B.L. The First Three Years of Life. Englewood Cliffs, N.J.: Prentice Hall, Inc., 1975. ($4.95)
Dr. White divides the first 3 years into seven developmental stages, providing a comprehensive description of physical, mental, and emotional development. Also contains a detailed discussion of childrearing practices and toys and equipment.

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